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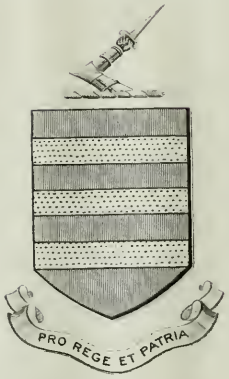

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COMMITTEE ON TRAINING OF HOSPITAL EXECUTIVES ISSUES MOMENTOUS REPORT*

IT IS becoming increasingly clear that the hospital has an important role in community health activities, in education of the community and the professional groups and in forwarding our knowledge of disease and its prevention. Present methods of meeting the demand for properly qualified hospital executives are quite inadequate. Reacting to this general situation, a conference of representative groups from various parts of the United States and Canada was called together by the Rockefeller Foundation early in 1920 to consider the problem and to suggest a feasible method of dealing with it. After considerable discussion, the conference appointed a Committee on the Training of Hospital Executives to make appropriate recommendations. This committee assembled and reviewed the available literature on the subject and decided that a further direct study of contemporary hospital practice, organization and tendencies should precede any recommendations, and an executive secretary was secured to make such a study. The following report represents the result of the inquiry.

The committee feels that the report presents a reasonable basis for training hospital executives and for attracting into the field a group of individuals with proper qualifications for the work, and recommends that a course or courses of training of this general character be inaugurated under university auspices.

Report of Secretary

This report is an attempt to present a composite picture of the American hospital and to suggest a basis for training hospital executives. It is necessarily theoretical in character and represents the results of inquiries into a number of representative situations in various parts of the country, conferences with individuals acquainted with the problems involved and a digest of considerable literature pertaining to the field and to the principles involved.

At the present time there are between 7,000 and 8,000 hospitals of over 10 beds in the United States, having a total bed capacity of almost 700,000. Over 80 per cent are institutions of 100 beds or less, about 40 per cent of 25 beds or less and 75 per cent of all the hospitals of 500 beds or more are institutions for nervous and mental diseases. More than 40 per cent of the total number of beds are in these last named institutions although they constitute less than 10 per cent of the total number of hospitals. About 70 per cent of all the hospitals are in communities of 50,000 or less and 56 per cent of the counties of the country have no hospital facilities, although the bed occupancy in hospitals devoted to relatively acute conditions averages only 67 per cent.

The functions of a hospital fall logically into three major groups, with appropriate sub-divisions, and these functions are applicable to all activities within the organization—medical, nursing, social service, dietetic, laboratory, administrative and others.

Service to the patient is the major function and includes adequate care and every reasonable attention to his physical and mental comfort. It includes prompt, accurate laboratory, x-ray and other determinations and an interpretation of the social-economic environmental factors which may be contributory to the individual problem. A reasonably accurate diagnosis and a logical, skillful

*An abstract of the report of the Committee on the Training of Hospital Executives, appointed by a conference on this subject called early in 1920 by the Rockefeller Foundation. Members of the committee were: Dr. David L. Edsall, Dr. W. L. Babcock, Mr. John G. Bowman, Miss Elizabeth Flaws, Dr. S. S. Goldwater, Miss Annie W. Goodrich, Prof. Paul H. Hanus, Rev. Charles B. Moulinier, Dr. Frederic A. Washburn and Dr. Willard C. Rappleye, executive secretary.

treatment should follow an evaluation of the facts and data secured. To render the treatment most effective, a follow-up and after-care function which aims at convalescent care, reeducation and readjustment of physical or mental activities to secure promptly the highest degree of recovery and economic usefulness is necessary.

With proper safeguards, the hospital should have its entire facilities and personnel available for service to the community and to the practicing professional groups of the neighborhood, whose interests and those of the community in health matters are in large measure identical. Many of the present problems of medical and nursing practice are identified with the non-availability of hospital, laboratory and treatment facilities in small communities and with a denial of similar facilities to a considerable portion of the qualified practitioners in the cities.

The hospital in the broader conception should provide much of the education of patients and community formerly devolving upon the family physician.

Every hospital has the opportunity and an obligation to train hospital personnel, laboratory workers, social workers, supervisors, dietitians, physicians, nurses and others. Cooperative medical and nursing practice of some form, based upon the personal relationship of physician, nurse and patient and the responsibilities arising from such relationships, seems not only desirable but inevitable. Educational work in that direction can be done by hospitals, cooperating with the professional groups, better than by any other agency. The medical staff by proper organization can be readily converted into a graduate-practitioner training center with great benefit to the individual, the profession and the community. The contacts of this group and the medical centers in the neighborhood are only a natural development. Similar organization of the other professional groups is equally feasible and desirable.

The attitude of investigation and research should be developed in every hospital; it is fundamental to sound progress.

The hospital may then be defined as a community organization which provides facilities and personnel for rendering the highest possible grade of health services to patients, professional groups and the community; for educating the community to demand and support adequate health services and sound health policies, for educating additional personnel and professional groups in technical fields and in cooperative endeavor; and for advancing our knowledge of disease and its prevention through technical research and appropriate organization.

The plan of organization to execute these complex functions must be developed to secure the highest efficiency of performance at a minimum of effort and cost. The chief function of administration is to create an environment conducive to the spontaneous, creative expressions of the groups working within the organization and to relieve the professional workers as much as possible of non-professional and non-technical duties; to provide, then, the facilities and machinery by which the fullest expression of functions may most easily be obtained.

Hospital Organization

The unit of operation of the hospital about which the whole organization should be built, upon which all activities must ultimately converge and constituting the reason for the existence of the hospital and professional groups working within it, is the patient. Only through him and contacts arising therefrom can the hospital find its fullest expression of service. A patient in the last analysis is only a human being either with or threatened with incapacity, physical or mental. He represents the cross section of a human life and as such is the resultant of many forces in the past—hereditary, industrial, environmental, economic, social—which may have conspired to predispose or contribute to his present condition. It is frequently quite as necessary, then, to understand and to interpret these human and social factors as it is to appraise technical and biological factors in order to secure a correct diagnosis, to guide treatment intelligently and to propose methods of prevention. The administration of a hospital under this conception must necessarily be based on the community as the unit of operation, not the institution.

The hospital organization requires a governing board in which must ultimately rest the responsibility of policies and their execution and the appointment of heads of professional services. On such a governing board should be represented a diversity of interests and a group of people acquainted with the community to be served, who have qualifications for the position, a willingness to assume responsibilities devolving upon such a board and who know the essentials of sound administration.

The hospital executive should be the executive officer of this governing board, furnishing it with information upon which sound programs may be formulated and carrying into effect the hospital policies so determined. Only a rare individual can do this unaided and various groups advisory to the executive and in contact with the governing board should be created.

An appropriate administrative machinery un-

der the hospital executive is necessary to execute the complex functions.

A sound organization and adequate functioning of the administration alone are insufficient. The medical staff and other professional groups must be coordinated under proper leadership to secure the best possible treatment of the patients, to facilitate education and investigation and to permit of the soundest advice in matters of policy and community service. The growing tendency to fix accountability for professional and hospital performance necessitates the organization of individual responsibility and a method of securing collective expresssion of policies and standards.

The hospital executive, as executive officer of the governing board, stands between the policy determining body and hospital work and closely in contact with the professional groups. Such an officer should be able to interpret community needs, the methods to be devised to meet them, the objectives sought, the fundamentals of sound organization and administration, and be able to mobilize and direct the self-expression of diversified activities toward a common goal. The position of the executive must be clearly defined and he must be held responsible and be given commensurate authority for the performance of the duties indicated. The theoretical position of such an executive carries with it a dignity and an influence for good which challenges the highest degree of imagination and ability.

The present somewhat general conception of a hospital as a hotel for the sick with the superintendent an exalted steward or clerk, with little voice in shaping policies and less responsibility in executing them, does not attract executives of the grade suggested. The result is a natural lowering of the rewards, dignity and opportunities of the position, consequent penalties and the establishment of a vicious circle. It seems clear that there is a great undeveloped field in organization of community health services and the need can apparently best be met by the elaboration of our present hospital organizations which embody most of the essential elements. Placing the hospital executive in a position of real responsibility and authority in such a scheme and aiming at a group of properly qualified individuals to meet such responsibility and opportunity where it arises will present sufficient challenge to insure a response both in personnel and the rewards for such valuable services.

The growth of a sense of community responsibility in matters of health is leading to a demand for coordination of the diversified activities and professional groups concerned with these problems.

The hospital represents in general the common ground of most of these activities and groups and a type of organization which may readily be adopted to the functions of coordination, education and service.

It occupies a strategic position in the whole field of community health, and provisions for the adequate training of hospital executives would constitute a fundamental contribution to the entire program.

Such a training must necessarily cover too wide a range of activities for any one individual to master, and it should be largely devoted to providing opportunities for those of high ideals, ability and proper qualifications to secure a fund of sound knowledge and a properly supervised disciplinary training in the administration of hospital functions. It should consider the development of personnel and the furthering of our knowledge of organized community efforts looking toward the conservation of health and the prevention of disease as fundamental to any plan of training.

Executive Training

Most of the present hospital superintendents have either drifted into the work without special training or have come up through a system of apprenticeship. The former method is probably partly responsible for the present confusion and for the apparent failure of hospitals generally to measure up to the opportunities and responsibilities open to them. The latter plan has rendered an excellent contribution but represents a method of preparation for professional work now largely abandoned in other fields. Education in general has passed through the phases of apprenticeship, didactic instruction, demonstration instruction and is now evidently entering a phase of disciplinary training. Preparation for hospital administration can probably be readily adapted to this method.

The large proportion of hospitals in the United States and Canada are institutions of one hundred beds or less and as they are now conducted

cannot, for financial and other reasons, attract executives with the highest qualifications. But an elaboration of our present conception of a hospital to that of a community function and the coordination of a number of health activities under a central policy-determining organization should create a demand, offer ample opportunities and provide adequate rewards for leaders of the highest ability. This change will be gradual and provisions must be made and continued for developing superintendents of small institutions since these institutions will always play an important role in the program of community health. But the prime consideration must be given to the development of creative thinkers and leaders as directors of coordinated programs of community health services.

Preliminary Requirements for Training

The development of leaders is more a matter of selecting promising individuals and of providing opportunities for them than it is designating and giving any preconceived instruction. The foregoing discussion gives some idea of the activities of an executive and of the duties which he is expected to fulfill. The need of judgment, poise and temperamental fitness are indicated in a preliminary requirement which may be spoken of as maturity, though not synomymous with age. The complexity of the problems and the various fields of contact of the hospital demand of an executive a mental training and general fund of information which may be suggested by an educational requirement.

With proper elasticity in interpretation, a university degree or its equivalent should be prerequisite for the training. While it may not be possible to prescribe the content of the preparation, it obviously would be desirable that it include the elements of such subjects as biology, psychology, social science, physiology, bacteriology, chemistry and physics. Those with medical training and a fund of knowledge, aptitude and ability in administration have the greatest opportunity to contribute to the broad program. These requirements are in themselves insufficient without evidence or promise of executive capacity as such, the imagination to visualize programs and policies distinct from details, ability to manage personnel and groups and to act upon as well as to make wise decisions.

The subject matter of a "course" in hospital administration is entirely subordinate to the qualifications, ideals and ability of the student, yet obviously the executive must have relative knowledge of the various activities in the field and such knowledge is best secured through actual training. What may be designated as an elementary or basic course could be designed to present the objectives, ideals, function, organization, contacts and general features of hospital administration, serving at the same time as a method of learning the aptitudes as well as the limitations of the student. Such a training should embrace theoretical and practical work in hospital-community health problems. An intermediate course can well be provided for those who, for one or several reasons, will not take a full course of training. The major concern and the greatest contribution, however, should be in advanced work by and with a group of properly qualified individuals with vision, adequate training and industry, who can be developed into a group of leaders and investigators in the field of community health.

The length of these various phases of a common course must be determined in part by the subject matter to be covered and by practical considerations of the student and the field to be served. Concensus of opinion is that the basic course should probably be not less than twelve nor more than eighteen months. Since it requires about four months to cover adequately a period of practical instruction in hospital operation, and a period of two months should be allowed for visiting other institutions and for final conferences, a total period of fifteen months seems to be the optimum length of the basic course, allowing a full nine months (corresponding to a university year) for the theoretical-demonstration work. Possibly additional work in summer session should be given.

Subject Matter for Basic Training

Without attempting to set up a schedule of subject matter, the following list of major topics for the theoretical training is given largely in an attempt to present something concrete and to designate the relative importance of each for a symmetrical preparation for hospital administration. Since individuals with different training and experience may become students if such a course should be established, it is necessary to have considerable latitude in schedule to permit of substitutions and electives. Some elasticity should also be permitted to allow expression of features particularly well developed at any place where such training might be given or to fit peculiar aptitudes of certain students. The schedule suggested is not given as a curriculum but may serve as a basis for qualification to do advanced work or for completion of the elementary course. Under each major topic are placed a few random suggestions as to the ground to be

covered by such topics without any attempt to present a complete subject matter.

I. Public Health (20%).
- Major disease groups, their causes, methods of treatment and prevention.
- Communicable disease control, community, institutional.
- Social factors in disease, ignorance, poverty, vice.
- Vital statistics, hospital statistics.
- Statistics of morbidity for community, patient's records.
- Health insurance, sickness insurance, contract medicine.
- Mental hygiene, delinquency, relation of crime to mental diseases.
- Community sanitation and hygiene, application of principles to hospital.
- Industrial hygiene.
- Relation of hours of work, sleep, diet, fatigue and normal physiology to health and disease.
- Activities of public health departments, state, national.
- Organizations in field of public health, their aims, ideas and operation, group medicine, visiting and public health nursing, etc.

II. Social Sciences (15%).
- General definitions, principles, history.
- Standards of living, poverty, education, recreation, unemployment.
- Urbanization, causes, results of concentration of population.
- Principles and agencies of relief, voluntary, governmental, local.
- Health as a sociological problem, responsibility of government for health protection.
- Rural problems, factors relating to health.
- Principles of community organization, political science, economics.
- Tendencies in sociology.
- Publicity.
- State medicine, problems incident to it.

III. Organization (15%).
- Fundamentals of organization, responsibilities, governing boards, machinery for administration.
- Internal hospital organization, departments, advisory groups, delegation of activities and responsibilities.
- External contacts, agencies of the community, professional groups, political machinery.
- Correlation of laboratory, x-ray, radium, social service, nursing, dietetics, ambulance service, visiting nurses, operating rooms, out-patient department, follow-up and after-care services, etc.

IV. Hospital Functions and History (10%).
- History of medical and nursing practice, traditions and education.
- Present tendencies in medicine and nursing, various suggestions to meet problems.
- History of laboratories, social service, dietetics, special therapies, their relationship to each other and to other activities.
- History of hospitals and their tendencies, foreign and American.
- Position of hospital in community activities, present conception, tendencies.
- Functions of hospitals and modifications of such functions.
- Methods of care of sick, hospital and other methods.

V. Business Science (10%).
- Definitions, theories of production and distribution.
- Distribution of industrial risks, insurance of various kinds.
- Cost accounting and interpretation, elements of bookkeeping.
- Budget making, various types of accounts, collections.
- Purchasing and selling, financing of capital and maintenance charges of hospitals.
- Various forms of revenue, endowments, sustaintaining funds, community chests, state or municipal support, contributions, bonds, trust funds.
- Records of performance of departments, office records and reports.

VI. Institutional Management (10%).
- Principles, definitions, purposes, lines or responsibility and contact, management of departments such as kitchen, laundry, engineering, office, units of the hospital, storeroom, housekeeping, etc.
- Economics and methods of curtailing expenses of operation.

VII. Personal Administration (5%).
- Labor problems and labor management.
- Psychology of work.
- Efficiency, rewards, methods of increasing responses of workers.
- Functions of labor in production.
- Handling professional groups and departments.

VIII. Community Hospital Needs (5%).
- Classification of hospitals.
- Needs of the community for medical and nursing services.
- Needs for hospitals and dispensaries, for various types of hospital beds, determining factors of industrial and social life, area to be served, population to be served, living conditions, etc.
- Distribution of hospitals and their size, relative to present and probable future demands.
- Other facilities in community for medical and nursing care.
- Support in sight for an adequate program.

IX. Physical Plant (5%).
- Location, construction, ventilation, heating, lighting, refrigeration.
- Maintenance, alterations, repairs, equipment, depreciation, fuel consumption, etc.

X. Jurisprudence (5%).
- Elements of contracts, testimony.
- Responsibilities of and legal requirements for the practice of medicine and nursing.
- Legal responsibility of hospital in matters of autopsies, accidents, compensation, operations, laboratory findings, professional care.
- Principles of privileged communications.
- Professional testimony.

At the completion of this academic-demonstration-conference period of nine months, six months of practical work should follow under educational supervision, the first four months to be spent in

one hospital and the major part of the last two months to be spent in visiting hospitals of different types, sizes and organizations with the aim of learning adaptions and modifications which are necessary to meet different situations. A final period could be best spent in a seminar of interpretation conferences and discussions. This whole course should not produce a finished hospital executive but should provide a reasonably good background for future development either in the field of practical hospital and community health administration or for more advanced work in health economics.

Opportunities for Present Superintendents

Methods of stimulating and helping the large number of hospital superintendents now on the field will tend to elevate the entire level of health service. Provisions in a training center of promoting activities of this character would be highly desirable and helpful both to the field and to the center. Possibly some of these efforts and some of the activities described under research may be better delegated to some other organization in more intimate contact with the entire field, but somewhere there should be provided short courses, possibly some of them as segments of the regular basic training, unit courses, institutes of various kinds and the presentation of special courses for special purposes. The recent rapid development of university extension work and the promise which it brings opens another avenue for stimulating and helping executives now on the field. Such activities, however, cannot be used as substitutes for sound, broad training and should be developed with a proper understanding of their purposes.

The usefulness and very existence of any possible training center will be both measured by and dependent upon the spirit of investigation. Research activities must be inseparably identified with such a center if it is to realize the fullest conception of its function. The training and research should be developed as reciprocal activities of a single organization to insure mutual stimulation and singleness of purpose.

Specific questions relative to the location of any possible training-research center are beyond the province of this discussion. The aim of developing creative leaders with ideals of service to patients, the community, the professional groups, to education and research suggests the necessity for a proper atmosphere for such a center, conducive to the fostering and furthering of such ideals. The atmosphere, however, is only one factor. The field to be served is practical and isolation to secure an ideal environment might comprise an eventual program. Wherever located, however, there must be reasonably accessible or likely to be developed in the near future, the facilities, machinery and teaching personnel necessary for presenting the fundamentals of the subjects discussed previously. Such material and personnel are represented for the most part in well established schools of arts and sciences, business administration, medicine, nursing, public health, engineering and where well developed hospitals, dispensaries and social agencies are available. All of these need not necessarily be present in the same city but a close educational supervision must be provided. The training suggested contemplates contribution from a number of sources but of greater importance than the mere contributions are the vision, teaching ability and attitude of those who will have charge of the instruction and supervision. The training should be under university supervision and the immediate direction of an individual of adequate university caliber.

Wherever possible, courses now in existence and present personnel should be utilized. Problems incident to assembling material and mobilizing courses and personnel in several major university and hospital organizations to apply on a comprehensive training program cannot be handled by someone whose time and energy are largely taken up by other activities. The manner of working out details of correlation and administration are matters to be studied in relation to practical suggestions as to where such a training course might be inaugurated. The financial considerations would include provisions for a department head, for administration, assistants and staff, possibly some compensation for personnel to secure and present special material not already available, for expenses of exchange instructors and lecturers, a budget for research, possibly a few fellowships and other incidental expenses.

Any possible training-research center should be effectively articulated with other activities in the local environment and should merge its interests and problems with those of other groups with which it has contact. Such a center may well become a powerful influence in local educational fields in its attempt to translate and interpret individual activities into a large composite program. It may serve later as a nucleus for the training of other groups of executives and leaders in fields allied to community health. In a somewhat similar manner it should be in close contact with national bodies working in the field, with which it must have proper orientation and out of which contracts much of mutual benefit should develop.

THE BEAUTIFUL ANCON HOSPITAL

By COL. L. T. HESS, U. S. M. C., Superintendent, Ancon Hospital, Canal Zone.

ANCON Hospital is one of the oldest landmarks of the Canal Zone having come into existence in 1883. Through its portals there have passed many thousands of patients. It has been intimately connected with the building of the Canal under both the French and American regimes and is now, as formerly, the hospital where nearly all the civil and military patients of the Canal Zone are sent who are in need of hospital treatment. Many persons from the Central and South American republics seek admission for treatment so that its renown is more than local.

Numerous requests have been received from hospitals, medical schools, physicians and others seeking information concerning the facilities and other matters relative to Ancon Hospital, and their questions suggested this illustrated article. It is hoped that it will be the means of a wider publicity of an old institution which has been proclaimed by many of the medical profession as the most beautiful hospital in the world.

French Built Old Ancon

Any description of Ancon Hospital would not be replete historically without a discription of this institution during the French regime and at the time it was taken over by the Isthmian Canal Commission.

The hospital proper was established by the Old French Company which erected the first building in 1883 on a reservation of about eighty acres on the northern and eastern slopes of Ancon Hill which commands an extensive view of Panama Bay, City and surrounding mountains. Ancon Hill is 654 feet above sea level. The grounds, on the eastern and northern slopes up to the 200 foot contour, were laid out, terraced and graded by the French Company and upon these terraces were erected the several wards and other buildings of Ancon Hospital. The buildings were of frame construction of the pavilion type with tile roofing but unscreened. The hospital was operated under contract in accordance with the terms of which people engaged in Canal construction were treated at the rate of five francs ($1.00 gold) per day. A result of this system was that very few Negro employes were sent to the hospital and the patients were, therefore, almost entirely white employes.

The Old French Company failed in 1889, but left a complete set of records in the hospital which show that from 1883 to 1889 over 5,000 deaths occurred at the hospital, 1,200 of which were from yellow fever. The old yellow fever ward was known as the "St. Charles," within the confines of which hundreds have passed to the "Great Beyond from whose bourne no traveler returns," many of them victims of these dreaded maladies—pernicious malaria and yellow fever. It is believed that more people died from yellow fever in this building than in any other hospital in the world now standing.

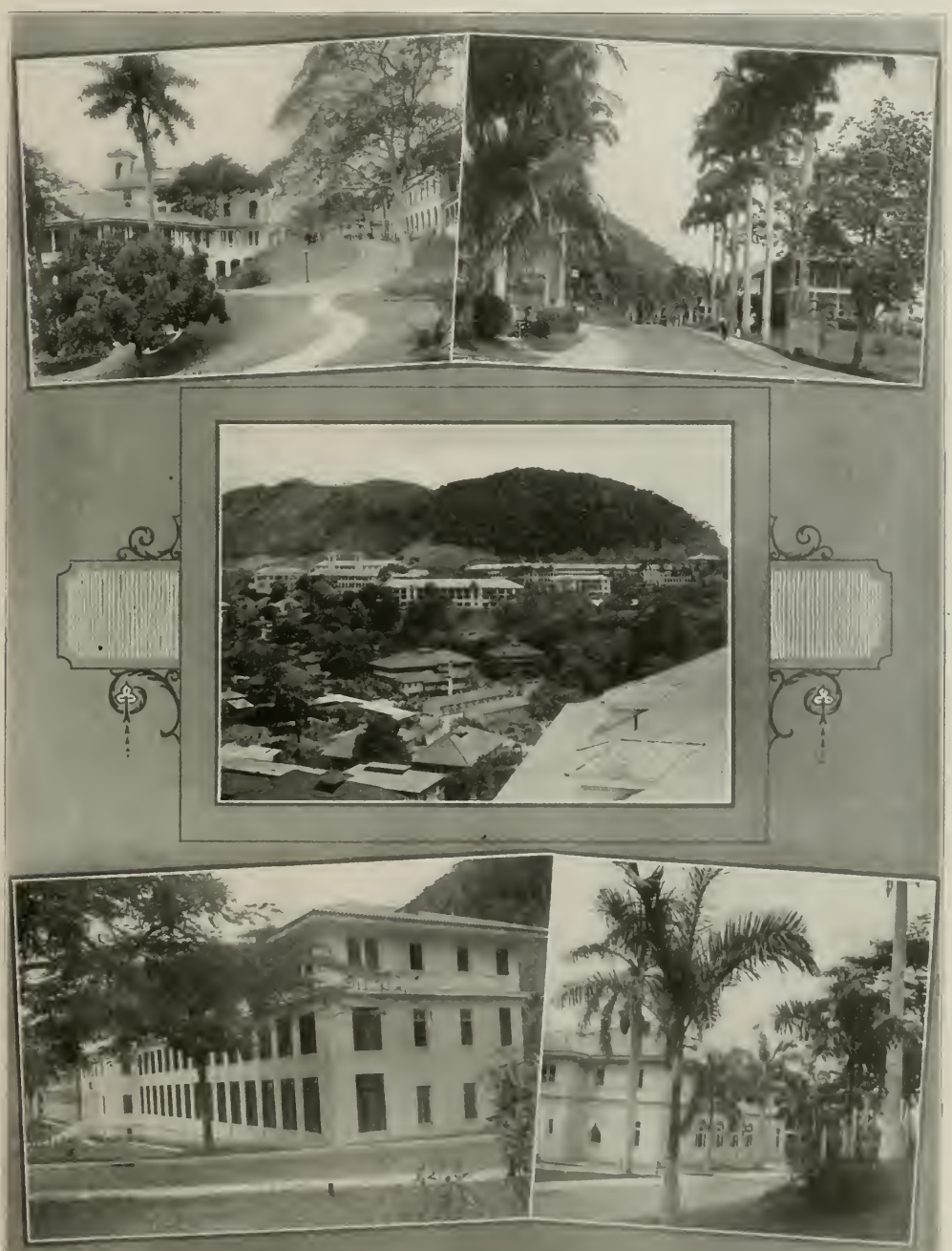
In this connection it might be of interest to record the fact that many cases of injury and minor illness admitted to the hospital developed, within a short time after admission, to yellow fever, and a large percentage of them died; in fact it appears that most of the yellow fever cases occurred

A panoramic view of Old Ancon Hospital showing the general layout of the hospital buildings erected by the French in 1881-1883, when work on the Panama Canal was begun, as remodeled by the Americans in 1904. These buildings were erected on a reservation of eighty acres on the north and northeast slope of Ancon Hill, which appears in the background. The large building at the extreme left is the old Administration Building erected by the Americans and originally intended for the residence of the Governor.

THE OLD ANCON, BUILT BY FRANCE AND REMODELED BY THE UNITED STATES

Stately royal palms border the main road (upper left) to Old Ancon—it is now Gorgas Road; bits of the old hospital grounds (upper and lower right) show the abundance of tropical vegetation; the old yellow fever ward, St. Charles (center), during the French regime; a screened cage within a screened ward (lower left) was Col. Reed's method of fighting yellow fever when the Americans took over the hospital.

OF FAR GREATER BEAUTY AND PERMANENCE IS THE NEW ANCON HOSPITAL



An interior view (upper left) of the new hospital grounds looking between the tall wild fig tree on the left and the mango tree, heavy with fruit, on the right; Gorgas Road (upper right); general view of the hospital from Tivoli Hotel (center); Section D of the hospital (lower left); admitting office and dispensary building (lower right).

among the patients admitted to the hospital so that those who entered did so with fear and trembling.

No doubt many, as in Dante's description of the Inferno, bade adieu to all things mundane before they entered the hospital. The reason for this was not discovered until the immortal Reed of the Medical Corps of the United States Army demonstrated beyond any doubt that yellow fever was due to the stegomyia mosquito whose favorite habitat and breeding place was in collections of fresh water in vicinity of habitations. It is strange that a noble act and love for things beautiful should result so disastrously to those for whom it was designed to benefit as demonstrated by the following incident.

Sister Marie Rouleau, the Sister Superior of Ancon Hospital, was a lover of flowers, plants and growing things. This propensity on her part, combined with her desire to increase the revenues of the hospital, resulted in making the grounds a veritable microcosm of plant life on the Isthmus. There exists on the Isthmus a voracious ant commonly known as the "umbrella" ant, so called because it carries bits of green leaves, umbrella fashion. To prevent destruction of plants by these ants they were surrounded by a low concrete wall with a narrow, shallow gutter filled with water over which the ants could not navigate. These pools of fresh water were ideal places for breeding the yellow fever mosquito, so that the patients admitted to hospital located in the beautiful flower garden became victims of these disease-producing mosquitoes; hence so many deaths occurred among the non-immune patients admitted to Ancon Hospital.

Was Quickly Remodeled

The Americans took charge of Ancon Hospital in May, 1904, the late Col. Louis A. Le Garde, Medical Corps, U. S. Army, being the first superintendent.

The work of clearing up the grounds and repairing buildings was at once begun. Not more than $50,000 was spent in putting the buildings in a habitable condition. All buildings were screened, some new ones built and a second story was put on some of the buildings so that within the hospital reservation there were in all ninety-six buildings in thirty-two of which were forty-seven wards with a total capacity of about 1,200 patients.

All the wards had modern equipment of the United States Army standard and were provided with lavatories, closets, showers and bath tubs. The operating room was spacious and the equipment was thoroughly modern and complete as were the eye, ear, nose and throat and x-ray departments so that the old Ancon Hospital, although of wooden construction, when completely remodeled and refitted by the Americans compared favorably with the hospitals in the United States and afforded every facility for up to date treatment of all classes of cases.

U. S. Government Builds New Ancon

The Panama Canal was completed and opened to traffic in August, 1914. Since then the government has expended many millions in development of terminals and in municipal improvement. Most of the construction is of a permanent character—reinforced concrete or semi-concrete and hollow cement curtained wall cement stuccoed or lime plaster.

The most beautiful group of buildings from an architectural point of view is the one comprising new Ancon Hospital. This group of buildings supplants the original French wooden hospital buildings and was erected on an irregular and restricted site crowding the base of Ancon Hill, overlooking the bay and city of Panama, with a beautiful vista of the mountains in the distance.

The style of architecture is a modified Italian renaissance. The plan adopted was isolated "sections" or ward units as far as possible, without departing too far from the economy of central administration, and this idea together with the irregularity of the site fixed the height of buildings at from two to four stories.

Shelter from tropical sun and rain is afforded by wide corridors around all exposed sides of the ward units; also direct inter-communication between the sections or ward units is afforded by loggias and continuous porches, which connect the various wards with the administration-clinics building and the kitchen and mess building.

The construction is of reinforced concrete, with hollow cement block curtain walls and partitions, cement stuccoed outside. All roofs are covered with vitrified Spanish red tile; inside walls and ceilings of concrete and plaster, generally painted with a washable paint. Porches and outside openings are copper-screened against insects. For the most part, all floors are of six-inch red ceramic or white hexagonal tile or cement; the latter for the porches. A few of the offices have yellow pine floors.

The general plan of the five ward groups, exclusive of isolation section, is two wards on each floor with auxiliary rooms between such as visiting room, ward dining room, ward and diet kitchens, cells and quiet rooms, doctors' and nurses' room, dressing room, ward laboratory, toilets and baths, service room, closets, elevator and stairs.

Isolation Section is four stories in height, with a normal bed capacity of 113, and emergency

SCENES ABOUT THE LARGEST HOSPITAL SOUTH OF THE UNITED STATES

The end of Section B (above) is hidden by the Bougninvillea vine in purple bloom; the home of seventy-two nurses (center left); Section C loggia (center right) leading to the dining room, kitchen and administration building; Section I (lower left) is the isolation ward where all contagious diseases occurring in the Canal Zone are detained until cured; a typical ward at Ancon (lower right).

capacity of more than 155. On the different floors are small wards and rooms with separate beds, so arranged that all classes of contagious and infectious diseases can be isolated without any danger of their spreading. It is not an unusual occurrence to have at one time eight or ten varieties of contagious or infectious diseases in this section.

Section "B" is the section for private pay cases, obstetrical, gynecological, and the medical and surgical ward for white women. There are forty private rooms, capable of accommodating forty-five patients.

Administration Building Is Center

The central building of the hospital group is the administration-clinic building, containing the pharmacy and drug manufacturing department, the surgical, medical, eye and ear clinic, the operating pavilion of four operating rooms in suite, x-ray department, administrative offices and record room, library and general assembly rooms; and in the basement it is contemplated to install a hydro-electric-therapeutic department. It is also contemplated in the near future to establish in this building a clinic for the treatment of genito-urinary and skin diseases.

Back of the administration building is the kitchen and mess building, where all the cooking and baking for the hospital is done and where also is located a large refrigerating plant. On the upper floors are dining rooms for the convalescent white patients and for the nurses and interns. On the second floor is the dining room for the convalescent colored patients and colored employes of the hospital.

The buildings are all equipped with electric passenger and freight elevators, automatic dumb waiters, fire protection, running hot, cold and ice water, steam, telephones, annunciators, direct and indirect lighting, and the latest in plumbing and hospital equipment throughout.

The hospital, exclusive of the insane department, has a bed capacity of 880 beds, which can be increased to about 1,200 in an emergency.

The entirely detached structures of the hospital are the power plant and shops; admitting and dispensary building, where individuals with ailments not considered serious enough to warrant care in hospitals are treated and prescribed for.

The Board of Health laboratory is designed for research and study of tropical diseases and contains the offices and especially equipped work rooms of the chemist, bacteriologist, pathologist, entomologist, embalmer, photographer, and the library and other offices. An inclosed passage communicates with the crematory.

The nurses' home is a three-story building with a social hall and individual rooms and porches for seventy-two nurses.

The superintendent's residence is the only permanent building so far erected for the staff of Ancon Hospital. It is contemplated in the future to erect a series of concrete buildings to provide quarters for the rest of the staff.

Largest General Hospital South of U. S.

Ancon Hospital is the largest hospital on the Western hemisphere south of the United States. It is also the only hospital in this region that is able to handle any class of cases, as it has all the modern equipment and apparatus necessary for diagnostic purpose and operative procedure.

In addition to the buildings described above the insane department is located about three miles from Ancon at Corozal. This institution is comprised of a number of wooden buildings, two stories in height, specially adapted for the housing and treatment of insane patients. There, too, are maintained the chronic cases who are able to do a certain amount of work and who do not wish to be repatriated. Cripples, who have been injured in the line of duty while employed with the Panama Canal and who do not desire to be returned to their native land, are taken care of at Corozal and perform such work on the farm, piggery and dairy located there as they are able to do. It has a bed capacity of 425.

The total number of admissions to Ancon and Corozal Hospitals during the fiscal year ending June 30, 1920 was 10,393. The average number of patients treated per day was approximately 882.

During the year 1,994 major and 4,831 minor surgical operations were performed. Three thousand one hundred and thirty-four visited the out-patient department of the surgical clinic, for whom 391 prescriptions were written. Three hundred and fourteen obstetrical cases were delivered.

In the out-patient department of the medical clinic 2,611 cases were treated, for whom 1,707 prescriptions were written.

In the out-patient department of the eye and ear clinic there were 7,443 cases for whom 2,606 prescriptions were written. Refractions numbering 967 were made and 976 operations performed.

In the x-ray clinic 3,333 cases were handled, 7,197 plates and 1,708 dental films were taken, and 84 treatments given.

In the dispensary (district physician) 104,737 were treated.

In the insane department at Corozal Hospital 521 were treated.

Ancon Hospital, while a U. S. government institution, is not a military hospital, although all

military and naval persons on the Canal Zone needing hospital treatment are sent there. The superintendent, since it was taken over by the Americans, has always been an officer of the Medical Corps of the U. S. Army.

the means of dissemination of knowledge of hygiene, sanitation and prevention of disease with the ultimate result that all quarantinable diseases will disappear from the western hemisphere, as every patient from South or Central America, in

The imposing entrance to the beautiful Ancon Hospital with Gorgas Road in the foreground. Between the center columns of the connection loggia can be seen one of the towers of the Administration Building.

The professional staff of Ancon Hospital, including the insane department at Corozal, is appointed from civil life with civil service status and consists of thirty-three physicians and six interns, including chiefs of medical, surgical; eye, ear, nose and throat, x-ray clinic and laboratory. All physicians devote their entire time to hospital work and do not engage in private practice.

The nursing service consists of a chief nurse and ninety graduate nurses appointed from civil life with civil service status. In addition there are employed 126 colored attendants and forty-seven maids, mostly Jamaicans, who are trained for nursing service.

Represents $3,000,000 Investment

The construction of New Ancon Hospital was begun in August, 1915, and completed in June, 1919, at a cost of nearly $2,000,000. The present equipment represents nearly another million. It has been proclaimed by many as the most beautiful hospital in the world. Americans can well be proud of having such an institution located as it is midway on the western hemisphere, to which all peoples of whatever race, color or condition can gain access for treatment of any disease to which the human race is heir, with assurance that it will be the best obtainable anywhere. It is money well spent and has been, as it will continue to be an important factor in creating a better feeling for us among the Latin-Americans; it will be addition to being cured of his ailment, will observe the excellent results of the health department of the Canal Zone in its campaign against disease, a campaign which has converted a "pest hole" of former days into a health resort, from a place where formerly the white men came to die and to a place where he now comes to be restored to health.

This claim may seem visionary; however, what has been accomplished in the Canal Zone in the way of sanitation and prevention of disease is possible elsewhere, and, if the healthful conditions which now exist in the Canal Zone as a result of the health department's efforts also prevailed in other countries of Central and South America, there would be no need of any quarantine restrictions.

The geographical location of Ancon Hospital renders it very accessible to the people of Central and South American republics who are in need of surgical and medical treatment, since numerous ships ply between the ports of these countries and the ports of Panama (Balboa) and Colon (Cristobal). Those coming to Colon, at the Atlantic entrance to the Canal, have at their service the Panama railroad to transport them to the Pacific entrance to the Canal, where Ancon Hospital is located on the slopes of Ancon Hill overlooking the Panama City and Bay with a beautiful vista of mountains and savanas in the distance. Located, as Ancon Hospital is, amid a ver-

itable microcosm of beautiful and rare tropical plants, trees and shrubbery, it affords patients ideal surroundings which act as a panacea for restoration to health. This, combined with quiet, freedom from flies, mosquitos and other insects, aids greatly to the quick recovery of the sick admitted to Ancon Hospital. Due to the rigid sanitation of the very efficient health department, the Canal Zone, including the cities of Panama and Colon, have become a health resort where one can come and enjoy the salubrious climate and cool nights without the fear of contracting diseases as was the case during the early days of the building of the Canal. The hotels Tivoli and Washington and others of Panama and Colon afford commodious accommodations for sightseers and all are interested in seeing the marvelous engineering feat, the Panama Canal, which connects the two oceans.

The skilled professional and nursing staff of Ancon Hospital and its unexcelled equipment afford the sick treatment equal to that obtainable in the best hospitals in the United States or Europe. In treatment of cases of tropical diseases, it is unsurpassed by any hospital. Hospital fees are moderate and cheaper than similar institutions elsewhere. The rates are $5 per day for ward treatment and $7.50 per day in private room. This includes board, lodging, medicines, nursing and medical attendance. Extra charges are made for surgical operations, $5 to $500, depending on the nature of the operation, for x-rays, for private bath, private telephone, and special nurses requested by patient. Companions are admitted at the same rates. The only condition required is that deposit must be made on admission of $150 or $225 U. S. Currency, depending on whether ward or private room treatment is desired.

Although a government hospital erected primarily for the treatment of sick employes of the Canal Zone, patients from any part of the world are admitted and accommodations are available at all times for ward and private room patients. Each is given the very best treatment that professional skill can devise with view of restoring the sick to their normal condition.

HISTORIC HOSPITAL BURNS

The historic hospital, Santo Spirito, in Rome, founded by Pope Innocent III in the twelfth century, lies in ruins following a disastrous fire on May 18. Santo Spirito was one of the most ancient and picturesque charitable institutions in Rome and accommodated 5,000 patients, including general hospital patients, insane, foundlings, and the aged and infirm.

Twenty persons lost their lives in the fire, which started in the laundry at midnight. The flames soon spread to neighboring wards and patients became panic stricken. Doctors and nurses soon removed patients from some of the wards, others crawled out, but as firemen arrived a heavy beam fell, the pavement collapsed and twenty chronic patients were buried.

Santo Spirito is situated on the bank of the River Tiber not far from the Vatican. Founded by Pope Innocent III in the twelfth century, it was enlarged by Innocent IV the following century and rebuilt under Sixtus IV in the fifteenth century. The altar in the hospital chapel was designed by Andrea Palladio and is reputed to be the only work of this artist in Rome.

SOCIETY MAINTAINS LINEN SUPPLY

At the Middlesex Hospital, Middletown, Conn., the problem of maintaining the linen supply is very satisfactorily taken care of by the Middlesex Hospital Aid Society. This organization is composed of over 1,000 women from the entire Middlesex County. They pay a yearly fee of $1 each and assist with all sewing. In order to cover all of the territory, the county is divided into fifteen districts, each under a local chairman.

A requisition for the linen needed during the coming year, together with a sample of each article is sent to the executive committee of the society. They assume all responsibility for filling this requisition. The materials are ordered and cut by a committee. When this is completed, the articles are sent to the chairman of the various districts who in turn distribute the material to the members of the society for sewing. The finished article is then sent to the main linen supply room of the hospital. This is not only a great financial aid but relieves the housekeeper of much planning.

Ancon Hill forms an ever-verdant background for the hospital, the Administration Building and Sections A and B of which are shown here. The interior terraced court contains the mango tree (left) and varieties of the palm leaf palm.

A PLEA FOR SMALL GROUP CARE OF THE INSANE

By P. S. WATERS, M.D., Assistant Superintendent, Alton State Hospital, Illinois

DEALING as we do with abnormal physical and mental conditions in the inmates of our state institutions we are apt, if we are not exceedingly careful, to accept and maintain false standards of living for them. Our greatest obligation to the mentally unbalanced who come to us for care and treatment is to guide them back into a normal relationship to society and it is with this particular idea in view that the following facts are presented concerning the establishment at the Alton State Hospital of what we may term *small group* care of the insane.

Illinois, like many other states, maintains at great expense, large institutions many of which in part at least, have been built according to ideas now obsolete. The care of patients in large groups has a tendency on account of a monotonous and desultory mental life to place them in a groove and hasten deterioration. Patients with persecutory delusions and hyperquantivalent ideas are considerably irritated by conglomerate ward associations so that large group care has a tendency to defeat the very end desired. So far as possible we should strive to individualize our patients more, hence this argument for small group housing.

Water fowl, raised by their own care, swim the quiet waters of a small lake and present an invigorating and healthful sight to the mental patients at rest after their day's work.

Farm colonies with their small groups enable us to come into closer contact with the individual in almost natural environment, to study his peculiarities and to remove his difficulties. The writer, after three years of observation and experimentation with this form of care, is convinced that it has a distinct therapeutic value, offering a more hopeful outlook to a larger number of patients than any other form of care introduced in recent years. The farm colony idea, of course, is not a new one. There are farm cottages in all the institutions of Illinois and many other states but almost invariably these are large buildings holding from forty to sixty patients and are viewed as industrial wards for patients concerned in the various activities of the farm. The most important qualification for residence in one of these cottages, as they are usually maintained, is the patient's proficiency as a farm laborer.

A better plan, as we view it, came into vogue at the Alton State Hospital rather accidentally when the thousand-acre hospital farm was taken over by the state and we came into possession of a number of buildings upon the various tracts of land formerly occupied by the tenants. Comprised in this acreage were two large brick buildings, one large frame dwelling and three small frame structures. The question of utilizing these buildings most profitably confronted us. They were in various states of dilapidation; one had even been condemned and ordered destroyed by state officials. All building for the insane had ceased in Illinois during the period of the war and out of our consequent perplexities at Alton arose the present idea of the farm home care of patients, thanks in a great degree to the ability of Dr. George Zeller, superintendent at that time, to visualize the possibilities that lay in a few scattered farm houses. These farm homes were soon occupied by patients and the work of their repair in which the resident patients assisted was commenced. From these old farm houses four cheerful, sanitary and very livable homes were constructed, housing now about sixty-four of our male patients.

These farm homes for the patients, accommodating from sixteen to eighteen each, neither from their exterior nor interior appearance, advertise the fact that they shelter the insane. Rather they give the appearance of ordinary countryside homes; and within they are filled with the atmosphere of home life. It is this "home and fireside" air that emphasizes the difference of this idea from that of large group care. Every patient added, above this small number of a dozen and one-half, the writer feels will subtract a corresponding amount from the value of the home to the individual.

Of course it may be argued that the farm home is impracticable because it is too expensive to administer with a small number of patients. The cost of the upkeep, in the minds of many, is still a paramount issue, either as a cold business proposition or because of forced economy, the latter

condition being the more common. It is only necessary to visit these homes once to see that, so far as the patients' benefit is concerned, they are at least 100 per cent more efficient than the large group wards, and we are able to manage them at no greater per capita expense than the average ward. We place in charge of these homes a man and wife. The latter is charged with the care of the home while the former is a farm laborer in charge of details. Married couples are much happier employed and remain in the home continuously so only one employe per day is charged to each home. The housewife's work is pleasant and homelike. We always have many waiting for these positions. She trains her cook and household assistants, usually three or four inmates are required for these duties, and gives much time to overseeing the raising of poultry, which is being done on a considerable scale in connection with some of the colonies.

Should Avoid Institutional Architecture

And here, moved by the contrast, the writer would urge the construction of more homelike buildings, as free as possible from the marble and tile and the cold aseptic air so often seen in the construction of our ward buildings. We are not caring for patients accustomed to wealth and luxurious appointments at home.

In times past we have failed in a great measure to consider the value of environment as a remedial agent. There has been too much of the artificial and not enough of the natural. We have been taught to call our inmate a patient and in consequence everywhere about him he sees evidences of the hospital idea; the gowned nurse and white-coated attendant constantly remind him of the fact that he is handicapped. Why not substitute, in place of large impersonal structures for the care of from 30 per cent to 40 per cent of our institutional population, the "home and fireside" idea. Under ordinary conditions these cottages

Occupants of this home, Farm Colony No. 3, are employed at a dairy a short distance away.

Three small cottages combine to make a comfortable convalescent and reeducational ward for a few selected chronic cases. The presence of a baby in the house has been the biggest factor in restoring the patients to their normal interests.

can be built of frame and stucco to hold eighteen or twenty patients for about $8,000 each. They should house patients engaged in every form of industrial occupation, as well as convalescents and cases where a small group care seems especially intimated.

The patients of our Colony One take care of our horses and some poultry.

Colony Two is beautifully situated among large maple trees and overlooking a small lake; no other buildings of the institution are in view except two other colonies. Here we have specialized in the raising of water fowl and from a few pair they have increased to a point where several hundred can be seen any day swimming upon the lake, an invigorating and healthful sight for our patients when they sit upon the porch after their day's work.

Colony Three is a large farm dwelling, the occupants of which are employed in the dairy a short distance away.

Baby Restores Normal Interests

Colony Four, most interesting of all, is not essentially an industrial colony, but has been gradually developed as a convalescent and reeducational ward for a few selected chronic cases. It is an assemblage of three small frame dwellings, once located at different points upon the farm and now made into a very cozy little home. Here a number of recoveries have taken place and many patients have gradually improved. Some time ago a baby was born to the mother in charge of this colony and allowed to remain there with its father and mother. This was a fortunate thing for a number of the patients in whom a return of normal interest apparently began with the entrance of the little stranger into this oddly assorted group. One not having seen it can scarcely appreciate what the presence of this child means to the life of this little colony. Relatives of the pa-

tients located here rejoice in their good fortune and insist upon their remaining.

One of the members of this group, an artist, who had been in another institution for twenty-five years and most of the time in closed wards, has recovered. A small studio was arranged for him when he produced some quite creditable paintings. The little child, he often remarked, had brought a new interest into his life. He has now been away for the past four months upon parole and is earning a living by his painting. Others of the colony assist with poultry and garden and two work in the carpenter shop. Many others who have been upon the receiving wards for months with little or no improvement have shown a marked gain and even recovery in the quiet, cheerful atmosphere of their rustic home. We regret that space will not permit giving a more detailed report of these cases. The observation of their improvement has been the most gratifying bit of experience the writer has enjoyed during his connection with state institutional work.

Advantages of Farm Colony

To watch the progressive, day-by-day awakening of the stupid dementia praecox, who for years has been deteriorating, emphasizes more than words can tell the importance of environment as a therapeutic agent in the treatment of the insane. Occupational therapy, our latest and possibly most powerful reeducational agent, loses much of its potency because the patient cannot be removed from the mire of his congregate ward environment and into the stimulating atmosphere of rural home life. Let us hope that the day is not far distant when the state will grasp this opportunity and instead of constructing more large buildings will build a farm home type of structure for housing the occupational, industrial, vocational patients and as many of the convalescent, acute cases as can be treated in this manner.

The small group farm colony care of mental cases, then, has the following advantages:

1. It affords a quiet farm home environment.
2. It does away with the irritating effect of conglomerate ward associations.
3. It removes the hospital or mental invalidism atmosphere.
4. It represents economical construction and maintenance.
5. It permits the study of individual traits together with the gradual increase of individual responsibility.

Cooperative anti-mosquito work in forty-five town situated in ten southern states has cut down their malaria rate by 75 to 90 per cent, says the U. S. Public Health Service. It saved its cost several times (in one town eight times) in doctor's bills, medicine bills and lost wages, all of which are items that are ascertainable.

WITHIN THE ARCTIC CIRCLE

The northernmost hospital on American soil has recently been opened at Port Barrow, Alaska. On a bleak promontory that juts into the frozen Arctic is the village of Port Barrow with a population of nine whites, including a doctor and nurse, and 450 Eskimos.

Three hundred miles to the south and four hundred miles to the east of Port Barrow lie villages, the nearest habitations.

Hospital facilities are, of course, lacking in these outposts. The newly erected hospital at Port Barrow, the point farthest north in Alaska, will then serve the scattered Eskimo tribes over an area of 60,000 square miles.

To erect a hospital in this isolated region was a triumph of enterprise. Building materials were sent from the United States to Nome by steamship; thence from Nome to Port Barrow by small schooners. The journey had to be made during the fleeting northern summer and was beset even then with the perils of storm. The tiny fleet of schooners en route to Port Barrow became separated in a blinding gale and one was carried to the coast of Siberia.

The vessels were to carry 200 tons of coal for the use of the workers during the first year but only 55 tons were delivered and great hardship resulted.

Building materials arrived on the first of September, 1921, and workers set to work with all haste so that superstructure might be erected before the first of the heavy snows. The foundations were begun and in six days the big chimney was started. By the time the chimney had reached the height of thirty feet, however, a severe frost set in, and in order that the work might continue, a great bonfire was lighted and kept burning around the mortar, which was used steaming hot.

Steadily the work progressed to the amazement of the Eskimos who had never imagined a building so vast. The hospital is constructed of wood and wood-pulp board and is 70 feet long and 38 feet wide. The basement rests upon ice. In the basement are two hot air furnaces, to combat the frequent temperatures of 60 and 70 degrees below zero, and an electric light plant.

If the Eskimos were astounded at the magnificence of the main building, they were struck dumb with terror at the sight of the first electric light. Their early fear soon passed into childish delight and now it is said that their chief pleasure is in switching the lights on and off.

The hospital cost $35,000 and has accommodations for seventy patients. At present, however, it is equipped with only twelve beds. The staff consists of one doctor, one nurse, a housekeeper and a porter. More trained assistants are hoped for later.

SOCIAL SERVICE DIRECTORY OUT

A directory of the social service departments in hospitals and dispensaries of the United States and Canada prepared by Miss Ida M. Cannon, director of the Service Bureau on Social Work of the American Hospital Association, came off the press last month and is being distributed. It is known as Bulletin No. 43 of the American Hospital Association series.

In presenting the directory to the trustees of the American Hospital Association, Miss Cannon asserts that the information was accumulated for her use as director of the Service Bureau on Hospital Social Work but urges that the material compiled be considered for publication as an official report of the bureau so that it may be available to those interested.

A CHARITY HOSPITAL FOR CHILDREN

By ROBERT McE. SCHAUFFLER, M.D., Staff Physician, Children's Mercy Hospital, Kansas City, Mo.

THE Children's Mercy Hospital of Kansas City, Mo., is a 135-bed general hospital. The words of the cornerstone indicate its purpose: "In 1897 Dr. Alice Berry Graham founded this hospital for sick and crippled children, to be forever non-sectarian, non-local, and for those who cannot pay."

Please may I come in?

Its beginning was very modest—a few free beds for crippled children maintained in a general hospital by gifts solicited by Dr. Graham largely from theatrical folk, and from artists and musicians. The contributors were mostly people of small means but big hearts. After a time an old residence was secured to house the children, and soon a substantial addition of hospital construction was added. Members of Union Labor organizations contributed money and services. The present building was designed by Architects Wight & Wight, of Kansas City, and was completed in 1917.

Throughout the years of physical expansion the ideals of the founder have been preserved unchanged. Dr. Alice Graham and her sister, Dr. Katharine B. Richardson, are responsible for the Mercy Hospital of the past and present, and their influence will extend far into the future. The hospital presents an almost perfect blend of the ideal and the practical as exhibited in the character of these two self-sacrificing women. Since the death of Dr. Graham in 1913, Dr. Richardson has been the dominant factor in Mercy Hospital, devoting a large part of her time, strength and thought to the institution, entirely without financial remuneration. As one should expect, since the hospital was founded by women, is managed entirely by a central board of women and has a woman superintendent, the problems of good housekeeping have been carefully thought out and efficiently solved. No expense has been spared to obtain a maximum of light and air. Glass tile has been used freely in all toilets and dressing rooms as well as in the operating rooms. The floors are covered with battleship linoleum. The linen and sewing rooms are combined in a large, well lighted room. The linen chests are built in the room, like a library stack room. There are plenty of cedar-lined apartments. The store closets for fruit and food supplies would delight an old-fashioned householder. Out-of-doors, across the kitchen court, is a large cellar for the storage of winter vegetables. The inside partitions, between wards and halls or other wards, are largely of glass, thus lighting the wide halls where the nurses' desks are located and making it possible for the nurse to see what is going on in any one of three wards by merely turning her head. This is also convenient in that visitors can see the children without entering the wards. There are large enclosed porch wards at the ends of the building. There is a children's dining room on each floor and a large play room and a large school room are on the first floor.

The Children's Mercy Hospital of Kansas City, a charity institution.

The children's indoor playroom resembles an amusement park. It contains toys and games for all.

The building has a basement first floor which is wholly above the level of the ground throughout most of its extent. The second and third floors contain the main hospital wards. On the fourth floor are four units for isolation of contagious diseases, each complete with nurse's room, toilet, sterilizing room and food intake. The stem extending to the north contains kitchen and quarters for help on the ground floor and nurses' quarters above. It is hoped that the money to build a separate nurses' home can be raised in 1922, when this space will be available for additional patients. It was constructed with partitions which can easily be removed, and the plumbing was arranged in anticipation of this change.

Routine of Patients

Let us follow a patient through the house: He is examined in the out-patient department (west end, first floor); Miss Anderson, head of the home service department, is also head nurse and chief clerk during dispensary hours. Her assistant is out with a Ford coupe making visits or, in special cases, transporting children. If recommended for admission, the child's clothes are delivered to the parent and the little patient, in hospital garments, is taken up to the "wait-a-while" ward, (second floor, west). This is a room divided into glass cubicles for admission isolation. If the child has pneumonia it may be admitted to a porch ward, (also second floor, west). The overflow goes to a general ward (second floor, west) which will, at an early date, be divided into glass cubicles. Children are held in admission wards for from one to three weeks, depending on the individual case and the information at hand as to the prevalence of contagious diseases in the community and what diseases the child has already had. Children, referred for nose and throat operations, go to wards reserved for that purpose on the third floor, west. These cases are usually in the hospital only a short time and do not go to the dining room, play rooms or school rooms.

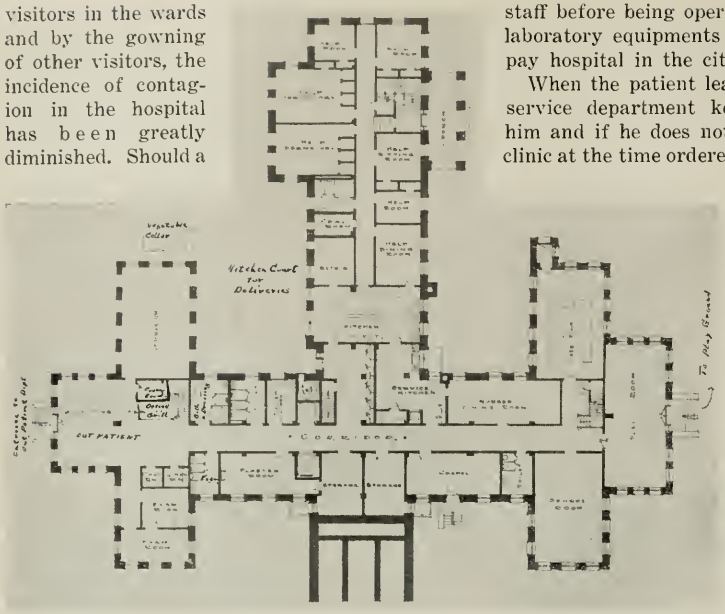
By admission isolation, by segregation of the nose and throat cases, by prohibition of child

visitors in the wards and by the gowning of other visitors, the incidence of contagion in the hospital has been greatly diminished. Should a child develop any contagious disease in the house ample provision is made for isolation of the fourth floor. After the new patient has been passed on to the boys' or girls' wards, everything is done to make him happy and contented as well as to cure his ailments. Very sick patients are in a quiet ward. The other two east wards on the two floors are pretty noisy; plenty of toys, all children possible are up on stretcher carts and kiddie cars, or are stumping about in braces or casts. They are encouraged to go to the dining rooms. There is a fine playroom on the first floor, east; also a school room with a regular teacher. A well equipped gymnasium and an outdoor playground are also at hand for the curative play teacher, who devotes her entire time to exercises and plays especially designated as of therapeutic value.

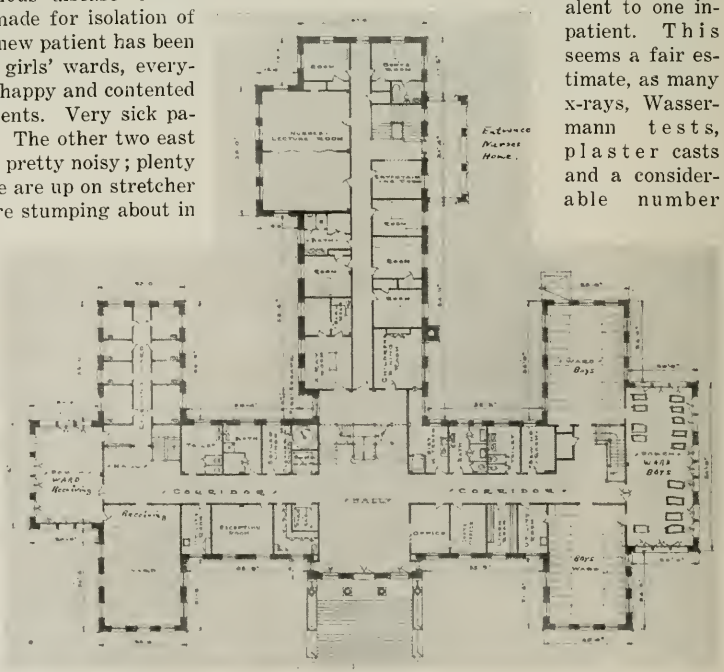
All cases are admitted to the medical department, and must be released by the medical staff before being operated upon. The x-ray and laboratory equipments are equal to those of any pay hospital in the city.

When the patient leaves the hospital the home service department keeps in close touch with him and if he does not report to the out-patient clinic at the time ordered he is promptly looked up.

The hospital is scrupulously clean, the air sweet and fresh, the food the best obtainable and all but the most desperate cases gain in weight. In 1921 there were 2,415 children admitted to the hospital who received 42,694 days of treatment; 10,704 children came to the out-patient department with a total of 27,948 visits; 2,454 visits in homes were made by the home service department. The total expenditure for maintenance, including all repairs and replacements, was $82,528. We consider four out-patients as equivalent to one in-patient. This seems a fair estimate, as many x-rays, Wassermann tests, plaster casts and a considerable number



Ground floor plan.



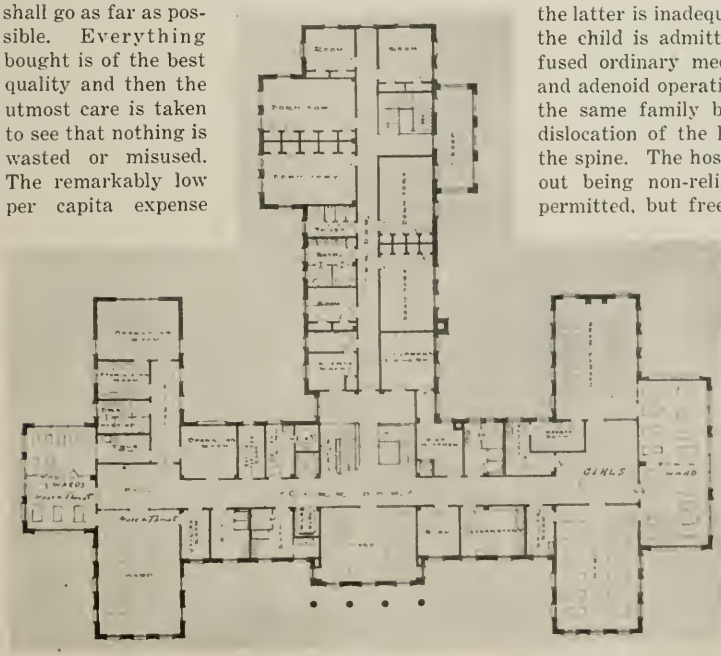
First floor plan.

of braces, as well as much home service work, are for the benefit of out-patients. On this scale the per capita daily expense is approximately $1.66. If the whole financial burden was charged to the in-patients and the 10,704 out-patient cases carried free, the rate would be only $1.93½ per capita daily.

Several features stand out prominently in my mind as distinctive of Mercy Hospital after my nearly twenty years of service on the staff. Mercy Hospital has been maintained by a multitude of gifts, most of them of small amount. Many groups of women and children have sewed and cooked for "Mercy," and have raised money for specific purposes through club activities. So much love has gone into the gifts that it is reflected in the spirit of the service rendered by the hospital. An earnest effort is made to conduct the hospital so that every dollar contributed shall go as far as possible. Everything bought is of the best quality and then the utmost care is taken to see that nothing is wasted or misused. The remarkably low per capita expense shows how successfully this has been accomplished.

Applicants are not treated as paupers. The need of the child is measured against the ability of the family to pay, and if the latter is inadequate for the particular need the child is admitted. A child might be refused ordinary medical attention or a tonsil and adenoid operation, but another child from the same family be admitted for congenital dislocation of the hips or for tuberculosis of the spine. The hospital is non-sectarian without being non-religious. No proselyting is permitted, but free access is given to rabbi, priest, or clergyman. There is a chapel which may be set for the religious ceremonial of any faith. Everyone connected with the institution is taught that the proper meaning of the word, "charity," is love, and that loving ministration to the afflicted is the purpose of the institution. The professional care of the children is furnished by a well-balanced closed staff. The hospital had only to adopt a new order of business for staff

Third floor plan.



Second floor plan.

Are you our big brother?

meetings to conform to the Grade A standard of the American College of Surgeons. There are no consulting members of the staff and no assistants. Each attending member is expected to take all the care of his patients and if the work becomes too heavy for him he is to divide the service with another appointee.

No child is refused admission where there is any reasonable hope that he may be benefitted. The child may stay as long as the attending physician desires.

Children who have been in the hospital a year or more show little evidence of being institutionalized. The freedom from red-tape, the general friendly spirit of nurses and attendants, the influence of the school teacher and of the play teacher, the many little treats and entertainments, all contribute to this happy result.

Mercy Hospital never stands still. It is always planning improvements and innovations and trying to do the old things better each year. The spirit of the founder, Dr. Graham, is still the guiding star of the institution. Dr. Richardson is the dynamic force behind its present activities and the dreamer of dreams for its future. She it is who raises money for improvements and expansion. Miss Mary Burman, the superintendent, and Miss Anna Anderson, head of the home service department, are the able field marshals and convert ideals into realities of efficient daily service.

The result is a model children's hospital, offering scientific medical attention of a high order in an atmosphere of loving consideration for little children.

NEW YORK HOSPITAL GETS HALF MILLION

The Society of the New York Hospital has announced a recent gift of $500,000 from George F. Baker, a governor of the Society. The donation, together with a gift of $250,000 made by Mr. Baker in 1912, will be used by the hospital board to establish the George F. Baker Endowment Fund.

The Society of the New York Hospital, operating the New York Hospital in West 16th St., the Bloomingdale Hospital for Mental and Nervous Diseases and the Campbell Cottages for Convalescent Children at White Plains is the second oldest hospital institution in the United States, having been granted a charter by King George III of England in 1771, one hundred and fifty-one years ago. Since that time the hospital has treated 2,018,000 patients, seventy per cent of whom, it is estimated, have been cared for free of charge.

All of the branches of the Society have been operated at a loss during the past ten years, the net loss ranging between $40,000 and $80,000 per annum, it is declared. Prior to that time the hospital's receipts were sufficient to meet all expenses because of the income from endowment funds created years ago. Campbell Cottages, where children from the wards of New York Hospital and other local institutions are taken after operations and where mal-nutrition cases are cared for, is absolutely free and causes the Society a net loss of approximately $50,000 a year.

PRENATAL CARE IN CHICAGO

What is probably the most complete and thorough study of facilities for prenatal care which has been made in any American City is described in the recent report of a survey by the Chicago Community Trust on "Prenatal Care in Chicago." The report shows that Chicago possesses too few institutional facilities for prenatal care of good quality and urges extension of this care, standardization and unification in the special training of physicians and nurses, and the development of an understanding public sentiment.

The Chicago survey found twenty-eight centers or stations in active operation. Large areas of the city, however, have no institutional prenatal service and in these neglected areas the report indicates that maternal and infant death rates are highest. All the clinics combined serve but little more than 10 per cent of the 57,000 cases in the city.

A schedule of standards which may be regarded as a minimum requirement for prenatal work is presented in the report for discussion and possible adoption.

TO ORGANIZE CAMPAIGN FOR AMERICAN HOSPITAL IN PARIS

The board of governors of the American Hospital of Paris has appointed two American women to organize bureaus of information for the hospital in United States and Paris. Miss Annie Flint, daughter of the late Dr. Austin Flint, one of the founders of Bellevue Hospital Medical College, will organize the bureau in the United States. Mrs. Henry Townsend Ashmore will open the Paris bureau.

So enormously has the hospital work grown since its foundation in 1904, that the present building with its thirty-two beds is inadequate to meet the needs of the American public in Europe. The board of governors has therefore decided that a complete new hospital of 100 beds—forty free and sixty paying—must be built. The hospital owns, approximately, 15,000 square meters of land. The funds in hand are sufficient to begin work on the new structure, which it is hoped can be inaugurated by 1924.

Already 12,000,000 francs of the 18,000,000 francs required for this hospital have been subscribed.

THE DEPARTMENT OF RECORDS IN THE HOSPITAL OF MODERATE SIZE

By M. GENEVIEVE MORSE, Muhlenberg Hospital, Plainfield, New Jersey.

When an inspector entered a certain hospital with an inquiry concerning a case record he was told that it was probably in a closet on the top floor. After a four-day search the case record was discovered. Although this is an extreme case, it illustrates for Miss M. Genevieve Morse her point that many small and moderate-sized hospitals are exceedingly lax in maintaining a department of records, due both to the difficulty of establishing a well ordered department in an institution already overcrowded and to the failure of many executives to realize the importance of records. The cooperation of all the departments is essential to the maintenance of an accessible and an accurate record department.

THE establishing of an up-to-date department of case records in a hospital of moderate size is a comparatively new thing, and to the average institution it is an undertaking presenting numerous problems difficult of solution. There is no place for a properly equipped record room in a building already crowded almost beyond its capacity. A trained worker to take charge of the department is hard to find. Chart-keeping and history-taking such as are required in the making of case records which are really valuable to an institution will mean the reeducation of the nursing force, the heads of special departments and the medical staff. A creditable and useful record department is not organized in a day, nor is it the result of one person's unaided efforts; it is dependent upon "a long pull, a strong pull, and a pull altogether" by the entire personnel of the hospital.

The three principal purposes of case records are: to furnish information regarding patients who are readmitted, enter other institutions, are seeking to collect damages for alleged injuries, etc.; to form the basis for the compilation of medical statistics; and to provide material for medical research. As a recent writer for THE MODERN HOSPITAL forcefully says: "Records are demanded in the interest of the hospital's and the physician's conscience, in the interest of the patient's and the community's health, and last, and perhaps most far-reaching, in the interest of the advancement of science. . . . The science of preventive medicine can only advance through the accumulation of facts. These facts mean records."

The need for an efficiently conducted department of records in any hospital purposing to keep up with the times may then be taken for granted. It is an important question, therefore, how in the organization and carrying on of such a department in an institution of moderate size, where hitherto but little attention has been paid to this line of work, there can be achieved that "pull all together" which is needed to attain the desired end.

Just what in the way of cooperation can and should be expected of those connected with other departments of the hospital's work?

1.—*The governing board and the superintendent.* That hospital which is fortunate has directors and a chief executive who realize the importance of properly kept case records—the "memory cells of the hospital's brain," and its only resource when inquiries come to it from any source regarding discharged patients. For upon these officers rests the responsibility of the organization, housing, equipment and support of the record department, and the engaging of its personnel. Case records of some sort have always been kept in hospitals, but their standardization requirements today are such that for their proper preparation and preservation there are needed a special room, adequately equipped, and a skilled worker or workers to take charge of them. It is to be hoped that few hospitals with any pretention at being modern in methods are in such case as one recently visited by a hospital inspector, where, upon inquiry concerning a certain case record it was stated that it was "probably in a closet on the top floor," and was only discovered after a four-day search. But there are still only too many hospitals where the record work is carried on under great difficulties, and where those in authority have not yet come to realize its importance.

A room in which case records and their card indexes can be locked up during the absence of the custodian is desirable not only as a matter of convenience, but in the interest of the hospital's reputation. Where this precaution is not taken, there is always the danger that these most intimate revelations of a patient's private affairs may be read and imparted to others by unscrupulous or morbidly curious hospital employes or others who may gain access to them. Such persons may even be induced to act as emissaries for outsiders

who desire to obtain certain information. The question of convenience is, however, hardly secondary. In a busy hospital the records are constantly being consulted by attending physicians, house doctors, dispensary clerks and social workers, while inquiries for information regarding discharged patients from other institutions, life insurance companies, legal sources, etc., are almost as frequent. A convenient place for the consultation of records and proper facilities for the rapid finding of what is desired will not only be appreciated by seekers for information but will add to the hospital's reputation for efficiency and public service. In addition to this, such work as the indexing of case records, making of case summaries, and tabulating of results for statistical purposes can only be done in a quiet place, removed from the turmoil of a busy hospital office. Finding space for such purposes, in an institution already needing enlargement in all departments, is often a difficult problem; but it is one worth very serious consideration.

Worker Must Know Medical Terms

Trained workers for record departments are few. A nurse who is well grounded in general medicine and has some knowledge of clerical work will usually succeed better than a commercial school graduate with no medical knowledge, except in an institution where there is a system requiring no initiative on her part. In a beautiful suburban hospital the direction of a recently organized record department was given to a young stenographer who was conscientious and hard-working but utterly unprepared from a medical point of view; notwithstanding, she was required to write all the case histories from the doctors' dictation. "Dr. Blank very kindly gave me a medical dictionary," she said to a visitor who marvelled that she could handle the situation. Even so, it is doubtful if Dr. Blank would have been willing to swear to some of his histories in a court of law. For this stenographer to have attempted to standardize the carelessly worded diagnoses often turned in or to write elaborate case summaries would have been out of the question. There are now one or two schools where excellent courses in record department methods are offered, but it is quite practicable for a nurse with a good general education and an aptitude for painstaking clerical work to acquire in a short time a sufficient knowledge of indexing, filing and typing to make her a very useful record clerk or historian, under careful medical supervision.

Office Data Must Be Accurate

2.—*The hospital office.* The record department is dependent upon the hospital office for accurate information as to a patient's name, address, age and other details which appear upon the bedside card. It is from this that the nurse filling out what may be called the title page of a patient's chart obtains a portion of her data, and it is these cards which are referred to when inquiries come to the record department for a patient's full name, address, etc. Carelessness on the part of the admitting officer may cause serious inconvenience to an attending physician or follow-up worker. For example, where the name of the city or town is not given in the address, as well as the street and number, follow-up workers may waste valuable time in looking for a patient in a wrong locality.

Most hospitals have a rule that in leaving the institution a patient on discharge must be accompanied by his completed chart and his bedside card, the latter duly signed by attending physician or intern, stating the final diagnosis and the condition of the patient when leaving. In hospitals lacking the clockwork-like system of the great institutions, however, the frequently inadequate staff allows such rules to fall into abeyance, and this is certain to mean trouble for the record department. Bedside cards arrive at the historian's office unsigned, lacking diagnosis or result; they remain on the wards until hunted up; or they disappear altogether. Charts are turned in in all stages of incompleteness; they may fail to appear at all for several days or even longer; they may even be actually lost, to the great embarrassment of the record clerks. The insistence upon the keeping of rules governing these matters must come from the executive office, which is thus in a position very largely to make or mar the work of the record room.

Writing of Histories

3.—*The attending physicians and house doctors.* The division of work in the writing of histories and physical examinations varies so much in different institutions that in considering what they can do to help the record department, outside physicians and surgeons and the interns must be spoken of together. Whether the case histories, physical examinations and progress notes are written by an attending doctor or house doctor or dictated by one or the other to a nurse-historian or record clerk, the real responsibility rests upon the officers of the medical board and the heads of the various services. The fuller and more detailed the history, the more valuable is the record, either in case it is required for use in a later illness of the patient, as legal evidence, or as material for medical research. Many doctors and interns shirk history writing and make as

short work of it as possible; yet they would probably be the first ones to complain of incompleteness, should they find upon consulting a record that it did not contain the information they desired.

Where case summaries are made, to be used for discussion at the doctors' staff meeting, little of interest can be obtained for the summary sheet from a meager, hastily written history. Promptness in writing histories and physical examinations is the only way by which accuracy can be assured; when these are left unwritten until after the patient's discharge they are sure to be less satisfactory, and the work of the record department is delayed. Progress notes on all suitable cases are now required by the "Minimum Standard" of the American College of Surgeons, and they add tremendously to the value of case histories, but they are only too frequently neglected and much information, which would render case summaries more interesting and provide material for medical research, is thereby lost.

A physician who treats a case must, in order to do so in an intelligent manner, have made at least a tentative diagnosis, yet an amazing number of case records have no working diagnosis entered upon them, although such diagnosis is one of the requirements of the "Minimum Standard." It is not even an unknown thing, in the smaller institutions, for a patient to be discharged without a final diagnosis having been entered in his record. "If you know what that patient had, you know more than I do," said a senior attending physician to a record clerk who asked for a diagnosis under such circumstances. Before such an attitude the record department is helpless.

Importance of Operating Room Records

4.—*The operating room.* Only the eternal vigilance and untiring perseverance of the supervisor will prevent failure on the part of the surgeons, anesthetists and her assistants to furnish the record department with all the information regarding operations for which they are responsible. If she would resolutely refuse (except of course in emergency cases) to begin an operation until the working diagnosis was entered upon the patient's chart and signed by the attending surgeon, the record department would not receive the records of so many cases in which apparently no diagnosis was made until after the operation. She should also ascertain that no anesthesia chart leaves the operating room until it contains all the required data and has been signed by operator and anesthetist. Surgical cases are those concerning which the largest number of inquiries come to the record room, and an anesthesia chart which fails to give the name of the anesthetist, the length of time consumed by the operation, the number and kind of sutures, drains, etc., which were used, or some other important detail, reflects little credit upon the institution and gives little satisfaction to the inquirer who desires to use it in legal proceedings or for research purposes. If the description of the operative procedures and the condition of the organs explored, which is required by the "Minimum Standard," is to be written on the anesthesia sheet, the supervisor should see that this is done by the anesthetist or whoever is responsible for it before the anesthesia sheet leaves the operating room. When a patient who has been operated upon comes again into the hands of a surgeon, the more the latter can learn of the operative procedures and findings, the better prepared he is to handle the situation and the better the patient's chances for recovery. In that case of ovarian cyst, was the ovary removed or the cyst merely punctured? In connection with that hysterectomy, was an appendectomy done? What was the condition of the stomach, or the gall-bladder, or the uterus, when that exploratory laparotomy was done? If everyone responsible for the reporting of an operation would put himself mentally in the place of the surgeon who may one day need all the information he can obtain regarding it, fewer inquirers would meet with disappointment. The hospital of moderate size seldom has an operating room stenographer, and if operations are to be properly reported it must be plainly understood who is responsible for the work, and no exceptions must be allowed.

Laboratory Records Should Be Prompt

5.—*The laboratories.* Almost as frequent as the inquiries received by the record department for details of operations are those regarding the results of laboratory examinations, especially the results of Wassermann tests and tissue examinations from the pathological department and reports of x-ray work. In small and sometimes in large hospitals these departments are understaffed, and if a large amount of work is done it is difficult to get out the written reports with sufficient promptness to insure their being entered in the charts of patients who only remain in the hospital a short time. Yet the absence of such reports when inquired for may mean inconvenience and loss of time when the patient is readmitted, comes to the out-patient department or consults an outside physician. No case record can be considered complete which does not include a report of every laboratory examination which has been made during the patient's stay in hospital. Coöperation on the part of the laboratory workers is thus of the first importance.

Carelessness in Bedside Notes

6.—*The nursing personnel.* In hospitals where modern methods prevail, the charting done by student nurses is carefully supervised and the required information is fully and precisely given. In well-kept bedside notes there is no room for question as to the time of admission or discharge, the condition of the patient on returning from the operating room, or any of the other details to which the attending physicians or the hospital authorities so often wish to refer. The properly instructed delivery room nurse ascertains that in every report of a birth there is stated who does the delivery; what anesthetic, if any, is given, and by whom; whether or not forceps are applied, and what kind of forceps; how many sutures are used and of what material, etc. For these and many other details of the nurse's part in the making of records the supervising nurses are responsible; but if student nurses themselves could realize how often their bedside notes, order sheets and temperature charts are scrutinized by attending physicians, and that any record is liable to be some day studied by lawyers, representatives of life insurance companies, etc., they would take more pride in having their entries full, correct, neatly written and properly spelled. The misspelling of medical terms might be pardoned in inexperienced students, but for such errors as "immergency," "opperation," "dialated," and "muster plaster" there is not the same excuse. Incomplete records are more often turned in by graduate nurses "specialing" private cases than by student nurses, in the up-to-date hospital. It may be said that earlier graduates received less careful training in charting than the student nurse of today, but it is difficult to see how any nurse desiring to be a credit to her profession can be satisfied to hand in bedside notes where the fragmentary report of a week's care of a surgical case barely covers one page, or can consider her duty done in describing a delivery when she has inscribed in her notes a single sentence: "The patient gave birth to a baby." These are not imaginary occurrences, nor are they isolated instances.

Cross Reference System Necessary

7.—*The out-patient department.* If there is a separate record system for dispensary patients, there should be some method of correlating the cases in the two departments of the hospital's work. Many patients attend one or more of the clinics before being admitted to the wards, while many others, after being discharged from the hospital, are directed to return to the out-patient department for further treatment. Or in after days they may appear with some recurrent or new ailment. In any of these instances, the record which has been kept in one department will throw light upon the work of the other; and for this reason there should be in use some system of cross reference, by which it can be seen at a glance whether or not a patient admitted to the hospital has already been treated in the dispensary, and vice versa.

The various departments of a hospital are like St. Paul's description of the human body: if the work of one is inefficient, the others share in the ill effects. Especially is the record department the victim of carelessness or neglect, antiquated methods and indifference to progressive ideals. The world moves, and one direction in which the hospital world is moving is toward the building up and making available, through the record systems of the nation's hospitals, a mass of medical information which is a most important source of that knowledge which little by little is gaining control of the preventable diseases which afflict humanity. All honor to those hospital workers, in lofty places or in lowly, whose efforts are forwarding this good work.

DEVISES NEW HOSPITAL GOWN

Mrs. George Thompson of New York and Oyster Bay has invented a hospital gown which is said to have met the approval and commendation of more than 100 well known physicians and surgeons of New York. Many declare that the gown is the most practical garment for the sick and bed-ridden they have ever seen because it can be removed in part or altogether without disturbing the patient in the slightest degree. It also simplifies and saves time, according to the physicians, when a patient visits a doctor's office, for it is so constructed that it can be worn at all times.. The inspiration for the gown came to the society woman when she was seriously ill in a hospital recently. More than anything she dreaded the annoyance and pain incident to the slightest motion. From that experience she worked out what she calls her "sick garment." This is how she makes it:

The back and front of the garment (whether it be pajamas or the old-fashioned night-gown) are made in two parts and are fastened together with snappers. In examinations of the heart and lungs all that is necessary for the nurse to do is to detach the snappers at the neck and shoulders and turn down one half of the front of the garment.

The sleeves are also attached by snappers, and one pull will bring an entire sleeve away so that a hypodermic injection may be given, the examination of a fracture made, or a soiled sleeve may go to the laundry.

If the garment is equipped with leggins, or is in the pajama form, it is made in two parts and can be removed in the same manner.

The young physician answered the telephone, and a beatific smile spread over his face as he listened, then replied:

"Very well, Mrs. Jones, I'll be right over."

Then hurrying to the office door, he called:

"Oh, Mary, my practice is sick again!"

LAUNDERING FOR A HOSPITAL GROUP

By WALTER T. WILLIAMS, Cincinnati, Ohio

As a general description of the Cincinnati General Hospital, the laundry department of which I am to describe, has been published in these columns I shall not give any details of the big institution which consists of twenty-four buildings occupying twenty-seven acres of ground and forming what is really a group of hospitals.

One would naturally expect the laundering for such a large institution to be an extremely difficult matter with many perplexing problems; but if there are either difficulties or problems in the laundry, they did not present themselves during my several visits to the plant. Dr. A. C. Bachmeyer, the superintendent of the hospital, has nothing but smiles and pleasant expressions when it comes to discussing his laundry department which is managed most capably by a young woman, Miss Anna P. Glendening who is also superintendent of the linen department.

The laundry department consists of two complete plants adjoining each other. One of these plants does the laundering for the wards which occupy seven buildings and contain 850 beds, four of these buildings with 150 beds being for contagious cases. The other plant does finished work principally for interns, nurses and general employes, but it also launders considerable flat work which comes from the dormitories. Both of these plants are efficient and turn out an excellent grade of work. One notable feature is that the wear on the fabrics is reduced to a minimum.

The plant that does the laundering for the wards, as may be seen from one of the accompanying illustrations, occupies a large room with light on three sides. On entering, one comes to the sterilizer, which is a washing machine built to withstand the pressure of steam. (For a general description of this washer see THE MODERN HOSPITAL, Vol. XVI, No. 4, p. 328.) This machine sets against the wall and in the back of its outer shell, leading into another room, is an opening with a steam-tight door.

The goods from the contagious wards come to this outer room and a man assorts the pieces and loads the washer. There is no contact between this man outside and the washman inside, such being made unnecessary by a simple system of signals. In both the rear room where the loading is done and in the washroom there are two electric signal lights, one of each pair being red and the other green. When the washman ends his day's work, he rotates the cylinder until its opening is even with the rear opening so that the machine may be loaded. Then he fastens the steam-tight door on his side, after which he pushes the button that turns on the green light in the other room, an action that automatically lights the red light on his side. The machine must not be used on the side where the red light burns, and a red light always is burning on one side or the other.

Each morning the man in the rear assorts a load of goods and fills the machine, after which he closes the steam-tight door on his side and displays a green light on the washroom side, his own red light being automatically displayed by the same action. The washing proceeds with the

View in the plant in which the laundering for the wards is done. The sterilizing washer, shown in another illustration, is located at the left of the long line of washers which are shown in this picture.

A section of the plant in which the laundering for the personnel is done. This is a complete finished-work plant in which is done all the work for the interns, nurses and other members of the force.

usual formula for the class of goods in the machine, just the same as it would in any other washing machine. Then steam is admitted for twenty minutes, at a pressure of fifteen pounds, which gives a temperature of 250 degrees F. Next, the load is removed from the machine, is put into a truck and sent to the extractor. The cylinder is set opposite the loading door, the door on the laundry side is closed, the green light is displayed at the rear, and the process is repeated as before. Thus no person in the laundry is exposed to contagion.

The other equipment of the ward laundry consists of five large washers and one small one, with galvanized shells and brass cylinders. Electric drive, direct-connected, with panel control is used on these, but the sterilizing washer has an independent electric drive of the ordinary type. Two large over-driven extractors and a small under-driven one take care of the output of all of these washers. The drying is done by means of one conveyor dryroom, one rack dryroom and one small drying tumbler. The flat work of course is not dried but goes direct to the flat work ironers. There are two of these machines, one with seven rolls and the other with six and their combined daily output averages about 9,500 pieces.

A section of the nurses' locker room to which the laundry delivers the laundered articles, placing uniforms on hangers.

A section of the hospital's linen room showing the work as it is delivered by the laundry department.

Although not a part of the laundry, a big steam sterilizer of the stationary type may be said to be an adjunct. This apparatus stands in the room in which the goods from the contagious wards is received and from which it goes into the steriling washing machine, and it is attended to by the man who assorts and loads the washer. Mattresses and other large articles are sterilized in this, including pillows; sometimes the pillows are washed.

View in the assorting and wrapping room.

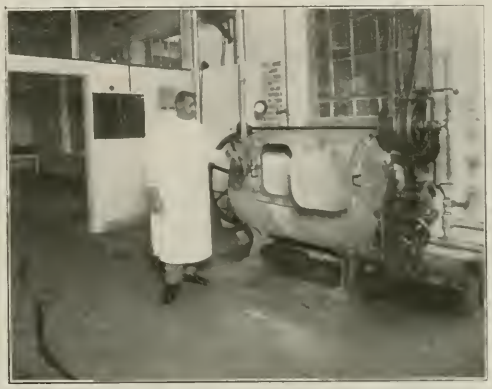
The second plant or "personal department" is a complete finished-work laundry that handles everything to starched collars, and in it is done all of the laundering for interns, supervisors, nurses and other resident employes including the general help.

The marking room of this section is unique in the fact that although the department each week launders nearly 6,000 pieces of personal goods, belonging to several hundred individuals, it practically does no marking. An exception is made in the case of the thirty-five interns, articles belonging to them are marked; but the 165 nurses, the eleven supervisors, and the 250 other resident employes, making a total of 426 persons, must do their own marking or otherwise their bundles will be returned to then unlaundered. Each person is given a supply of small tapes, marked on the marking machine, and it remains for each individual, male or female, either to sew on the

Electric truck bringing a load of soiled goods to the laundry. This view shows the receiving room of the ward laundry which has ample storage capacity for the large volume that goes through it.

tapes or get someone else to do it. Each makes a list of goods sent to the laundry, and in case of error the sender is notified but the work proceeds.

This laundry is in a light and pleasant room with large windows on two sides and contains the following equipment: two large ashers, galvanized shell with brass cylinders, and a small one of the same type, all with direct-connected motors and panel control; one large over-driven extractor and a small under-driven one; one starching machine with starch cooker and other accessories; one shirt press with yoke, cuff and neckband presses; one drying tumbler; six pressing machines arranged in three tandem units; one two-roll flat work ironer; one collar ironer with necessary finishing machines; nine hand ironing boards with electric irons; three stationary tubs for washing fine articles; one marking machine, motor-driven.



The big sterilizing washer in which all goods from the contagious wards is washed. This is the washroom side into which the washed and sterilized load is discharged. The soiled articles are put into the washer through a door that opens into another room in the rear.

General Methods Employed

The methods in these plants are much the same as the standard methods used in others. One notable exception, and it is worthy of adoption, is that the bleach bath has almost been eliminated. Only a very small amount of bleaching is done in the plant that does the ward work, and practically none is done in the individual plant. All sour baths are made up with acetic acid.

The assorting is done in a small room that is located between the two plants. In one corner of this cheerful room near windows filled with growing plant is the desk of Miss Glendening, superintendent of the laundry department.

The personal work is delivered by the laundry to the different dormitories or wards in which it belongs. The ward work is sent to the linen room, and from there it is distributed to the wards on requisition. Here, it may be said, rests the only laundry problem that confronts Dr. Bachmeyer; it is caused by a shortage of linen, due to the fact that the hospital's allotment of funds for fabrics is not quite as large as desired. But this problem, like all others which confront him, ultimately will be solved by the doctor. As matters now stand, it sometimes happens that the same linen must be washed twice in one day.

Taking into consideration the large amount of work done, the expense of operating the two laundries is remarkably small. The plant is operated by an unusually small number of workers. Including the superintendent the laundry department has an average of thirty-seven employes with a payroll of $1,760 per month. Seventeen of these are residents, receiving their meals and lodging, and the twenty others receive only their meals. The average expense for laun-

Stationary steam sterilizer in which goods are disinfected when it is not desired to wash the articles. The rear door of the sterilizing washer opens into this room and through it the machine is loaded.

dry supplies is about $350 per month.

The ward linen, taking an average month, consisted of 283,000 pieces of flat work. The labor expense was $855 and the expense for supplies was $198, making a total labor-and-supply expense of $1,053.

In an average month the personal department laundered 28,000 pieces of starched work and 22,000 pieces of flat work, a total of 50,000 pieces. This includes work from the women's dormitory, nurses' home, contagious dormitory and administration building. The labor cost was $905 and the supply cost was $128.

Thus we see that the average gross cost of laundering for the patients was but $2.07 each per month, or a little less than 52 cents per week. The average cost per capita for officers and employes was almost the same, it being only $2.06 per month, or 51½ cents per week.

HOSPITAL LIBRARY EXHIBIT OF INTEREST AT A. M. A. CONVENTION

The central point of interest in the American Library Association Exhibit of hospital libraries at the recent convention of the American Medical Association in St. Louis was the demonstration of the three methods of book distribution to hospital patients now in use throughout the country: government service, public library service and private hospital ownership service.

The government service is the outgrowth of the work done by the American Library Association at the time of the war, which proved of such value that the government has now taken over this branch of the work. Each hospital is provided with an adequate collection of books and magazines and has its own librarian. The library itself is available to the patient who is up and about, while the bed patient receives reading matter through the ward distribution. The librarian is able to help in reconstruction work by supplying technical books and pamphlets that have a bearing on the practical training going on in the work shops. This feature of government work was well demonstrated by the Walter Reed Hospital exhibit.

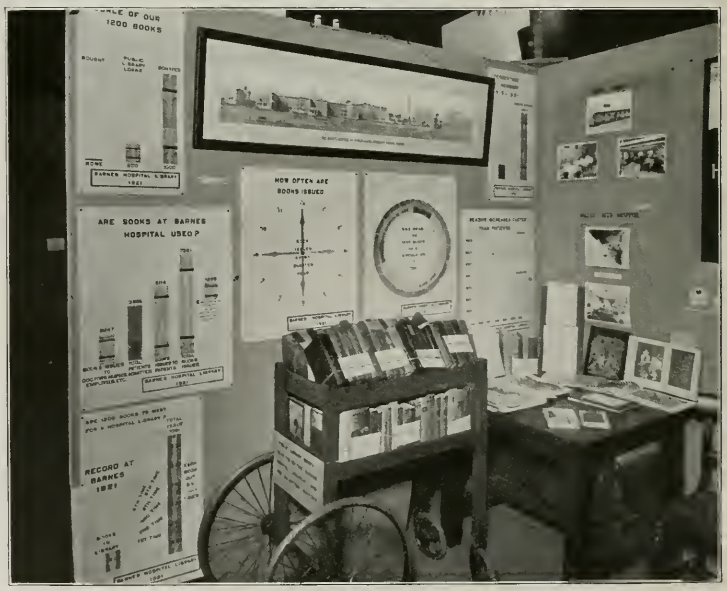
The public library service developed a new phase of activity after the war, when certain librarians who had served in camp libraries desired to extend the service to civilian hospitals. Sioux City Library, Sioux City, Iowa, the first to add a hospital librarian to its staff, had a telling poster showing photographs of the library surrounded by the seven hospitals receiving its service. The general plan for such work is as follows: The public library appoints a hospital librarian and places a collection of books in the hospitals selected for this service. Once or twice a week the librarian goes to each hospital and distributes reading matter through the wards.

The hospital ownership service antedates the work in government hospitals. For many years hospitals have had books that are more or less available to patients. Generally such collections are unsupervised. There are, however, a number of hospitals with appointed librarians. The Barnes Hospital at St. Louis demonstrated this type of hospital service. The exhibit consisted of graphic charts showing the possibility of providing and distributing reading matter to patients and employes with practically no cost to the hospital. The seven graphic charts shown in the illustration demonstrate the source of books (costs), use of books and increase in the activity of the library.

A digest of the charts show there have been no books purchased. In 1921 patients' reading was one-third more than number of patients admitted; that seven-tenths of all reading is done by patients; that a book is issued every quarter of an hour in an eight-hour day; that each book if read equally in the 1,200 collection must be issued more than six times; and that the increase of patients 1915-1921 was 94 per cent while books issued for the same period increased 624 per cent.

The book truck used for bedside distribution, with titles selected from actual experience, was shown, and the entire exhibit was explained by the volunteer workers of the Barnes Hospital and a former worker in the Sioux City Library hospital service.

The Barnes Hospital Library was organized in 1915 under the supervision of the record keeper. The work of issuing books, keeping a record of the issue, and shelving books is carried on by members of the record force, who



A prize exhibit of hospital library methods at the recent American Medical Association convention in St. Louis. This exhibit represents the library service at Barnes Hospital, St. Louis.

do this along with their other work. This, with the exception of cheap cards, constitutes the only cost to the hospital, for the affiliation with the public library, donation of books and magazines, and volunteer service for ward distribution, etc., provide the books and necessary service.

Volunteer workers come twice a week, fill a book truck suitable for bedside distribution and go to the wards. The nurse in charge is questioned and she designates which patients are not to be disturbed. An attempt is made to fit the right book to the right patient. A highly nervous person would be given an entertaining but non-exciting book, while the patient suffering from a newly acquired fracture would receive any kind of absorbing and exciting reading matter that might serve to shorten the days of pain and tedium.

Honorable mention was given Miss Elizabeth Green, Barnes Hospital, St. Louis, for a demonstration of methods used in distributing books in hospitals, by the committee of awards on scientific exhibits.

THE PROPOSED WAR WOMEN'S NATIONAL MEMORIAL HOSPITAL

By MAJOR J. F. TOULOUSE, Field Representative, War Women's National Memorial Association, Inc., Albuquerque, N. M.

A national tuberculosis hospital, gigantic in conception, is being planned by former service men under government care at Albuquerque, N. M. which will cost $10,000,000 and have an endowment of $25,000,000. The proposed hospital will be known as the War Women's National Memorial Hospital and will honor the mothers, sisters and sweethearts of former service men in all wars.

It was among the hundreds of ex-service men who had been sent by the government to Albuquerque, N. M. for the treatment of tuberculosis that the memorial idea was born. Sixteen states have been visited on what they call their "gumshoeing campaign," and not one voice has been raised against the plan which in all its details follow.

A great central plant with forty-eight units for the forty-eight states will be erected, if the plan is carried out. Each unit will accommodate 200 patients. A central administration building will house all the offices, operating rooms and an auditorium seating 5,000 people. The accompanying photograph shows the architect's conception of the completed plant. Trost & Trost and George P. Hill, architects and engineers, have designed the structure.

The institution, modern in every respect, will cover one section of land (640 acres); the streets shown in the photograph will be one mile long. Auxiliary buildings will be erected to take care of nurses and other help and the four buildings shown at the corners of the plant are great sun parlors and reading rooms.

It is hoped and planned by those promoting the project that the memorial will become the national center of the tuberculosis research work of the nation, and with this in mind the National Tuberculosis Association will be appealed to to furnish the staff and management of the hospital.

The first appeal for funds will be made after a national organization is perfected; this appeal will be to the ex-service men themselves.

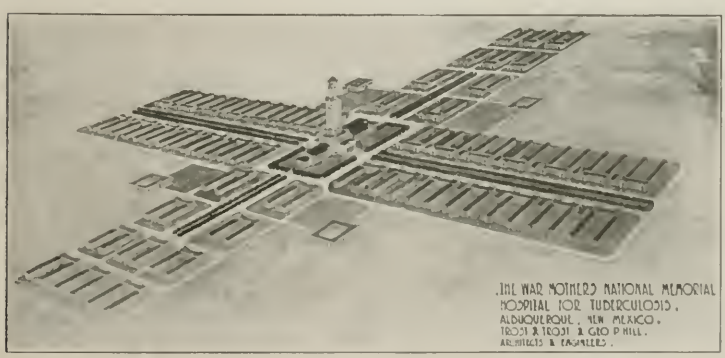
When the national organization is completed and a committee of five men nationally known have been selected to handle the money collected (not one cent going for commission), then the American ex-soldiers of all wars will be called upon to pledge one dollar for five years. It is estimated that 3,000,000 men, or half of the ex-service men of America will respond, making a total from this source of $15,000,000.

After that $20,000,000 more will be asked of the people, making in all $10,000,000 for the plant and an endowment fund of $25,000,000.

Any ex-service men or his dependent will be eligible for treatment in the hospital, according to the plan. In each state the ex-service men's organization will be the clearing house for that state's quota of patients. Just what the council of administration will decide on in the way of charges has not been fully determined, but it is the opinion of those who have been promoting the work that a charge of one dollar a day should be made, the earnings from the endowment fund to take care of all deficits after the money obtained from this charge has been expended.

The council of administration will consist of forty-eight trustees, one from each state, out of which a working organization of seven will be selected. This council will upon the advice and recommendation of the National Tuberculosis Association (if such advice can be obtained) select and employ a superintendent and such assistants as are necessary to conduct the work of the hospital.

Religion or politics will play no part in the building, organization and management of the Memorial Hospital.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ARCHITECTS & ENGINEERS.

HEALTH EXHIBIT IN SMITHSONIAN

The National Committee on Exhibits Showing Advances in Sanitary Science has recently been formed in Washington, D. C. for the purpose of collecting and preparing material for a great popular public health exhibit in the Capitol. The members of the committee include: Surgeon General H. S. Cumming, U. S. Public Health Service, chairman; Dr. D. B. Armstrong, National Health Council; Miss Mabel T. Boardman, American Red Cross; Surgeon M. W. Ireland, U. S. Army Medical Corps; Dr. Victor C. Vaughan, National Research Council; Dr. C. D. Walcott, Smithsonian Institution; James A. Tobey, National Health Council, secretary. Space for the proposed exhibit has been placed at the disposal of the committee by the Smithsonian Institution, which is visited by more than 500,000 persons yearly.

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THE HOSPITAL EXECUTIVE OF THE FUTURE

IN the concluding sentence of its admirable report, abstracted on pages 1-6 of this issue of THE MODERN HOSPITAL, the committee on the training of hospital executives records its conviction that any thoroughgoing plan for the training of hospital executives must include the development not only of efficient leadership but also of our knowledge of organized community efforts looking toward the prevention of disease and the conservation of health. This is the two-fold, inspiring goal which must serve as the controlling force in molding and, as time opens wider vistas of service, remolding an effective plan for the training of a high type of leadership in hospital and public health affairs which will, in the words of the report, "carry with it dignity and influence for good which challenge the highest degree of imagination and ability."

It is not enough that the efficient hospital executive of the future shall know merely how to operate his own institution efficiently, essential as that may be; he must so integrate his hospital with the community as to enable it to play an important role in any program of community health that may be inaugurated.

A thoroughgoing plan for the training of leaders of this type has never been fully formulated. The hospitals here and there that have hitherto trained hospital executives (we have no thought of belittling their efforts), have invariably followed plans that sought to develop superintendents capable of operating an institution narrowly conceived, rather than directors of coordinated programs of community health service. Nor does the committee's report attempt to formulate a plan for the training of such leaders. It merely gives a list of the major topics for their theoretical training "largely in an attempt to present something concrete and to designate the relative importance of each for a symmetrical preparation for hospital administration." The formulation of the plan is the work of the future. It cannot burst full blown from the brain of any one individual. Time and the contributions of many minds alone will bring it to full maturity. It will not be static; it will grow as the hospital grows. But the committee's report puts the plan of training at scratch and stakes the course. That, however, is something; a great deal in fact. Yet much, very much, remains to be accomplished.

But with all its inspiring idealism, the report does not wholly ignore the vital, though perhaps relatively less important, subject of the future training of the hospital superintendents now actually at work in the fields, pioneers many of them, who, often at great odds, have rendered a splendid service. Many of these will jump at the opportunity to take unit courses of a curriculum established on a university basis, whether through correspondence, institutes or by resident work during a brief leave of absence.

All in all, the report draws an inspiring picture of the hospital executive of the future and suggests a plan for his development. Which of our universities will be the first to undertake the task?

HOSPITAL SUPERINTENDENT, KNOW THYSELF

ORGANIZATIONS are like water; they cannot rise above their head. A hospital or other institution which is administered by a broad-guage, kindly mind is pretty apt to be a broad-guage place. The courtesy, the humanity and the spirit of service, no less than the business accuracy, the desire for the real advancement of the work in hand and the maintenance of high standards pervade the entire institution, if the head thereof is possessed of these qualities.

It is equally true that if he is slovenly in his mental and physical habits, if he is discourteous and overbearing, if he is a petty tryant, an egoist or a recessive, these traits will be reflected throughout whatever organization he may head.

Personality, to a certain extent, is a matter of environment and upbringing but, more than these two factors, individual thought is a great element in determining whether a man shall be slothful or overzealous, easy-going or officious, careless or meddling. The true appreciation of the rights and weaknesses of others comes from within. True charity and kindness, grouchy meanness and mental sadism come equally from the heart.

It is quite as true also that the correction of mental faults and the expansion of pre-existing good habits of mind are both in the hands of the individual himself; that he may alter or change these at will, if he will but will. Unfortunately, most of us are so blinded by the dazzling light of our ego that we cannot see wherein we may bring about improvements; in fact the thought never enters our minds that there is any need for a change. Perhaps we have reached mature age before the idea is finally rudely forced upon us that improvement is not only desirable but actually necessary. This is usually extremely painful but there is always the chance of seeking relief in the belief that one is too old to change, that the mental joints have ankylosed and that the best remedy is a mental strut to hide the mental limp.

But this is fallacious, for having discovered a mental fault, whether it be a domineering pettyness which makes everybody in the shop despise the superintendent or an invertebrate wishy-washiness which kills the respect which every employe should have for his chief, it is possible to correct the evil by a personal stock-taking and a genuine intention to eradicate the noxious habit and to cure the wound which its uprooting has made.

There is no class of institution which reflects more accurately the personality of its head than a hospital. The relations of the superintendent with staff and operatives are so intimate, the opportunities for close observation of the mental, moral and physical habits of the chief are so protean, that everything he does is known to everybody in the hospital. His life is a living secret of Polichinelle; his thoughts, his actions, his moods, his antagonisms are stones which fall into the shallow pool of the institution's being, there to produce ripples which spread to its uttermost rim. If he slyly infracts the 18th Amendment on occasion, he need not be surprised if some day a second cook plus a quantity of time-fuse, high-explosive, bootleg whiskey tries to chase the engineer out of the boiler room. If he is dictatorial with the head nurse, he may expect some probationer to be overbearing with a high spirited maiden lady who is scheduled posthumously to endow a ward. If he is unduly fussy lest the general public shall injure the buildings or grounds, he may look for equal, yes greater, fussiness on the part of the citizenship when he wants an appropriation for a new wing. In other words, in the end, the punishment pretty accurately fits the crime.

Desirable and possible as cure is, prevention is equally possible and even more desirable. The prime requisite to both is diagnosis.

One of the surest signs of an unhealthy mental outlook on the part of the superintendent is the comportment of the other employes. Thus surliness and inattention, brusqueness and impudence in any considerable amount in the nurses and attendants are fairly pathognomonic of the superintendent's condition. The book of hospital regulations is another trustworthy sign. If it is filled with admonitions and threats, with paragraphs which are continued so that the superintendent or his sub-chiefs may at any time trip the unwary, it is a sure sign of petty oppression, of a contemptible pneumothorax of the ego. The superintendent who catches himself putting signs in the buildings and grounds, "Don't Do This," and "Don't Do That," "Violators Will Be Punished," etc., may be absolutely certain that he is cultivating bad mental habits of which he must purge himself if he is going to be a useful man in a useful job.

The manifestations of egocentricity are myriad. They vary from odd little tricks of speech or gesture or gait and curious foibles of dress to cold-blooded cynicism or boorish rudeness. The important thing is that the condition shall be recognized either by the victim or some pachydermatous friend who will ruthlessly apply counter-irritation. The encloistered superintendent rarely can do the former for himself and has few friends to do the latter. Paradoxically, the superintendent who is really onto his job gets away from it. He goes to the Rotary Club; he gets out with the biceps-worshipers at the golf course or the athletic club; he mingles with his fellowman and acquires the humanity, humility and charity which come from standing at the other fellow's point of view and which are sure prophylactics against elephantiasis cerebri, ponderosity of the self-esteem, hypertrophy of the opinion, incompatibility of the ego, intolerance of the spirit and crabbed meanness of the disposition.

But these affections are not peculiar to hospital superintendents or to plant administrators, they are liable to occur in anybody who has the direction of the movements of others. Chiefs must therefore be on the lookout for them in themselves and they must watch for their appearance

in their subordinates. The latter is not as difficult or unpleasant as the diagnosis and treatment of one's own case.

UNDERMINING EFFICIENT BUYING METHODS

IN AN editorial in our June issue under the caption "Expensive in the Long Run," we pointed out how it is necessary as a matter of self-defense for concerns doing a national business to charge to the general sales expense whatever contributions they are obliged to make as a matter of business expediency to the hospitals which are unwise enough to solicit them for contributions and how this increases the selling price of the goods to all the customers, including the very institutions that solicit the gifts.

There is another phase of this subject that calls for discussion. The practice of soliciting contributions from the jobbers and manufacturers with which the hospital deals not infrequently destroys efficient buying methods and in the end seriously undermines the institution's finances. If a hospital resorts to this method of increasing its income the superintendent, to the degree in which he is successful in this practice, will be tempted to take the easier way and dispense with care in buying. "Why worry," he persuades himself, "about getting competitive prices and looking too closely into the comparative quality of goods. Contributions from our friends the jobbers and wholesalers make it inexpedient to exercise one's judgment quite so relentlessly. Smith, Jones and Company has contributed quite generously to our work; we must keep this company's good will and clinch next year's gift by deliberately turning business its way. To the limbo with efficient buying methods!"

Clearly this is a pernicious attitude to take; it is unbusinesslike and will bring the institution that permits it to grief. Hospital superintendents who value sound business methods as well as fair play, we need scarcely observe, will not tolerate the practice of soliciting contributions from business houses with whom they deal because such practice is uneconomical, unfair and unbusinesslike.

AN INTERPRETATIVE SERIES ON FORMS AND RECORDS

THE limited amount of time which the committee on hospital forms and records of the American Hospital Association had to prepare the report they submitted at the association conference at West Baden last September made it impossible to include any great amount of interpretive matter explaining the various forms included in the report and methods of using them efficiently. Our readers, therefore, will be glad to learn that in this issue (page 39) we begin the publication of a series of four papers prepared by the committee, in which the various forms and their uses are elucidated.

The first paper deals with the administrative records of the hospital; the second and third, both of which will appear in the August issue, deal with the records pertaining to hospital accounting and purchase and issuance; the fourth, the subject of which has not yet been announced, will appear in the September issue.

We bespeak a careful study of these papers in conjunction with the committee's report by all superintendents who are interested in improving this phase of the administration of their institutions.

NEW YORK AS A HOSPITAL CENTER

ON page 45 we publish that part of the summary of the study of hospitals in New York City by the Public Health Committee of the New York Academy of Medicine which gives a general idea of the extent of hospital facilities in New York City and their distribution by services. It is a most interesting and helpful presentation of facts and points out the difficulty of gauging accurately the hospital needs of the community by types of services because of the lack of morbidity data.

When the study is published in its entirety, it will undoubtedly be a most valuable contribution to the elucidation of hospital problems. Dealing as it does with the hospital situation in New York City, it is concerned with one-twentieth of the hospital field in the country and one-tenth of th hospitals of the fifty larger American cities.

Incidentally, we would like to call attention to the wide ramifications of the educational work of the New York Academy of Medicine under whose auspices the study has been made. Its work, although extensive, is chiefly of a local character and is perhaps for that reason not sufficiently well known to our readers outside of New York City.

The Academy was founded in 1847 and its aim, since its inception, has been the advancement of the science and art of medicine and the promotion of public health. The educational work is carried on directly by the twelve sections corresponding to the several specialties in medicine and surgery, and indirectly by the various agencies which have come into existence as a result of the activities of the Academy. The library which is said to be the second largest in the country is open daily to the public until 2 p. m.

In addition, such organizations as the Society for the Advancement of Clinical Study and the New York Association for Medical Education are domiciled in the Academy building and have the cooperation and good-will of the Academy.

The fortnightly stated meetings of the Academy, as well as the meetings of the sections, provide an unusual opportunity to the medical profession for post-graduate education.

The public health work is done through the Public Health Committee which has a unique and enviable record of uninterrupted work and achievement. It is composed of thirty leading medical men, who for the last eleven years have continuously given their time and thought to this work which is carried out by an executive committee. This committee meets every Monday throughout the year. The achievements of the Public Health Committee would probably fill a good sized volume. Only a few can be mentioned here.

It was through the Committee that the Associated Out-Patient Clinics of New York City was organized in 1912; this was the first association in this country that endeavored to formulate standards for the various types of clinics. Later on the Health Federation of the City of New York came into existence and functioned effectively for a number of years. As a result of the dispensary study in 1919, a Committee on Dispensary Development was established and several months ago, following the survey of hospitals, a Hospital Information Bureau was organized.

The methods of work of the New York Academy of Medicine and its achievements are worth the serious consideration and emulation of other medical bodies throughout the country.

FOR PSYCHIATRIC NURSES

FOUR years ago the Illinois State Department of Public Welfare established at the Chicago State hospital a school of psychiatric nursing.

The school was approved by the state licensure board. Special quarters for pupils and for classrooms were provided in a new home for nurses on the grounds of that institution, where is also located the State Psychiatric Institute.

The school offers a three-year, an affiliated and post-graduate courses. Pupils are paid from $18 to $22 per month and furnished board and room. The nurses' home is new and modern in every respect. Opportunities for surgical, medical and bedside instructions are good. Pupils of this school may obtain training in obstetrics and children's diseases in general hospitals. Pupils in general hospitals may have a year at this school for instruction in nervous and mental diseases. The plan was approved by all those interested in the development of the nursing profession.

The school has had uphill work to get pupils and students. During the war it existed with a few post-graduates and affiliates. Now a determined effort is being put forward to enlist pupils for the three-year course.

Indifference or opposition has been met among some of the general hospitals. Others make promises of co-operation. The southern end of the state has been very well combed for candidates. An effort is now being made to arouse interest in the north. Appeal has been made to womens' clubs and medical societies for assistance in getting pupils. Efforts bring out only a few pupils.

Evidently psychiatric nursing is going to have rough sledding in Illinois and probably in every other state. Among those who contemplate nursing as their profession there appears to be a dread of the mental patient or a doubt that a state hospital can give adequate training.

While no difficulty is experienced in obtaining plenty of women to act as attendants, even on male wards, it is very difficult to induce better educated women to give their talents to the assistance of the mental and nervous sick.

The fact should not be lost sight of that a nurse who has had psychiatric training will eventually attain a rank higher than that occupied by those who have not had it. For instance the young woman who can care for surgical cases in a mental hospital where she receives no cooperation from the patient ought to be far better qualified to care for sane surgical cases where the patient will cooperate. The same is true all through the category of sickness and disease. Ability to handle successfully mental cases suffering from physical illness must be a great value in general practice.

The idea that the state hospital cannot furnish training must be removed. Many of the states are developing these institutions to a point where nearly every specialty may be taught. Psychiatric nursing will stimulate this tendency. It merits the encouragement of the leaders in the medical and nursing professions.

Someone has advanced the opinion that the letter "e" is the most unfortunate character in the English alphabet because it is always out of cash, forever in debt, never out of danger and in hell all the time. For some reason he overlooked the fortunates of the letter, so we call his attention to the fact that "e" is never in war and always in peace. It is the beginning of existence and the end of trouble. Without it there would be no meat, no life, and no heaven. It is the center of honesty, makes love perfect. It is the beginning of eternity, the end of time and space. The beginning of every end and the end of every place. And without it there could be no editors, devils, nor news.

AIR SPACE PER PATIENT AND SOME FACTORS THAT INFLUENCE ITS DETERMINATION

THE question of the cubic feet of air space that should be allowed hospital patients is a constantly recurring one, and it constitutes a problem on which expert opinion is still at rather wide divergence. Believing that the factors of temperature and humidity must be involved in such a computation, in addition to the pure mathematics of ventilation, THE MODERN HOSPITAL recently sought opinions on the subject from a number of recognized health workers, physiologists, physiological chemists and hospital architects. Particular consideration of the problem of atmospheric conditions in wards was requested since on that hinges also the important question of preventing droplet infection.

Dr. Emery R. Hayhurst, professor of hygiene at Ohio State University College of Medicine, regards cubic space in hospitals or elsewhere, in the question of ventilation and atmospheric conditions, as quite subordinate in importance to the three fundamental physical factors of temperature, air movement and humidity. He further considers the chemical factors of air vitiation by exhaled breath or lack of so-called "fresh" air as also subordinate to the above mentioned physical factors.

Thinks Chief Factors Are Physical

"In fact," writes Dr. Hayhurst in this symposium, "I would place good natural *lighting* in hospital rooms ahead of the vitiation and 'fresh' air questions, although I would not be quoted as advocating the re-breathing of 'old' air to an unlimited extent. Several changes per hour is advised.

"In contagious hospitals, the amount of cubic space or, better, square feet of space, has relatively more importance than in other hospitals. In reality distance between beds is the critical point so far as atmospheric conditions go; the idea being to prevent transferred 'droplet' infection. Here twelve to fifteen feet between beds should be allowed in open wards with good daylight lighting (defined as from 40-foot candles on cloudy days to several thousand on bright days), or, where screens are provided between beds in wards, beds may be as close as four to eight feet with safety. The only real place where space is a question is in the prevention of "droplet" infection or actual contact between patients in the wards of the contagious hospital. In the usual hospital, the necessarily inactive patient who is without either fever or subnormal temperature, should be in a room temperature vacillating hourly between 68° to 72° F.; in a gentle air movement (0 to 2 feet per second) constantly pulsating or changing in direction and velocity as may be produced by a slow speed, quiet-running electric fan of the oscillating type located in the room or by baffled window ventilation and vents; and, with these conditions, a wet-bulb temperature hovering between 5° and 10° F. below the dry-bulb thermometer reading. I regard the thermometer as the only instrument actually necessary, however, if the physiological sense impressions of room 'freshness' on the one hand or 'stuffness' on the other are not noted upon entering the room and also after remaining in it for a time.

"Invariably the patient with fever should have a cooler room (60° F. if possible) with probably twice the air movement and about the same depression of the wet-bulb thermometer as just stated.

"The patient in shock, or with subnormal temperature, the 'weak' patient, or one while undergoing ether anaesthesia, (the latter particularly if for more than half an hour) should have the benefit of the normal conditions as stated for the patient without fever, plus handy arrangements for local heat to extremities and perhaps along the body, the amount to be gauged by the condition of the patient. In other words it is to be regarded as detrimental to 'hot-house' his whole environmental atmosphere simply to keep him warm. He needs the cooler atmosphere to play on his cheeks, face and neck and for breathing.

"Unquestionably the amount of the patient's skin surface exposed to the air of the room is a very important factor; any condition of 'slump' calls for more covering, especially if the auxiliary thermometer is also depressed.

Cubby Hole May Be Safe as Pavilion

"With these conditions observed I think it matters little whether space per bed is as low as 50 cubic feet, as it sometimes is in the bunk quarters of the naval vessels, or as much as 1,000 or 10,000 cubic feet. One may be just as atmospherically safe in a 'cubby hole' or closet, as in a great auditorium or pavilion. In other words it is a question of correct air conditioning and not cubic space. The large room is just as liable to bad air and conditioning as the small one. In fact it is more apt to be overlooked in the large room.

"In conclusion I would say that I am convinced many hospital rooms and wards—from the operating room to the recovery and convalescent quarters—are hazardously, although slightly, overheated with motionless air and that this greatly contributes to metabolic depression, as Leonard Hill so well states in his discussion of the physical factors of ventilation. As a minimum, I think every operating room and patient's room should be equipped with a reliable thermometer suspended from about the center of the room (not against the wall) and that nurses, from 'probationers' up, should be drilled to maintain temperature conditions within the suggested limits.

"More patients suffer from depression, thermic fever and some degree of heat prostration or heat exhaustion, due to a combination of high temperature, still atmosphere and excessive covering in the operating room and the hospital bedroom than is customarily given any thought. For instance, while in the operating room patients are usually closely covered from head to foot including scalp to which is added the anesthetist's mask covering most of the face (the face is the last safety valve in the mechanism of body temperature regulation), while operators, assistants and nurses in loose-flowing, short-cut gowns, perspire vigorously in spite of the square feet of skin surface exposed. What of the patient? It cannot be said that ether anesthesia demands this because of the great cooling effects of ether as it evaporates, for this effect is much too local, upon a limited portion of the nose and mouth, and is practically negligible in the modern gas-ether administration methods in which evaporation of ether is reduced to a minimum and is frequently at a distance from the patient; in fact it is often so slight as hardly to be noticed in the air of the operating room. Winslow and Greenberg say 'the commonest evil' is the room air of work places is the 'slight but

highly objectionable overheating'; while George T. Palmer considers this condition in school rooms one of the certain factors productive of respiratory affections. Also 'in an unvarying atmosphere,' says Palmer, 'the occupants miss that pleasant stimulative effect.'

"In my own experiments in air-conditioning the home,* I found that a temperature in my study of as low as 60° F. with proper humidity (50 to 60 per cent) and just perceptible air movement was, for hours at a time, a pleasantly invigorating environment and needed simply moderate variations to simulate a balmy spring day, or the cooler days of summer when, it will be noticed, even the hospital fails to provide artificial heat.

"It seems to me that anesthetists, surgeons and physicians should take the evidences already at hand for what constitutes a healthful atmosphere and aim at the temperature optimums which correspond to the three common conditions of metabolism (increased or febrile, normal and subnormal—the latter fortified by heat locally applied) and dismiss the bugaboo of 'cubic feet of space.' We are constituted to be so sensitive and responsive to physical air conditions that I regard them as of major importance in the recovery of patients from the first to the last day of hospitalization."

Clean Air Is the Necessity

"A minor detail in hospital ventilation" is the way **E. Vernon Hill**, acting chief of the bureau of sanitation, Chicago Department of Health, characterizes air space in its relation to hospital patients.

"It might be properly asked," says Mr. Hill, "how and to what extent does the air space per patient affect the air conditions therein, but as the air space itself in only one of a large number of factors too great emphasis should not be placed upon it.

"Most legal regulations are on this basis, but in the present state of our knowledge regarding the actual factors that influence and control air conditions it is clear that the standards at this time should be based on air cleanliness and the wet bulb temperature and not empirically on the cubic foot of air space per patient. Legal requirements for hospitals in the Chicago Code are as follows:

"Section 1218—Accommodations for patients—Regulations as to sanitation. In every such hospital each room occupied or to be occupied by patients shall be of such dimensions as shall give each patient not less than 800 cubic feet of air space. Every such room shall have at least one window connecting with the external air for each two beds. Said windows shall be of such dimensions as shall secure to each patient at least 2,400 cubic feet of fresh air per hour by natural ventilation. Or in case said window shall not secure 2,400 cubic feet of air space per hour by natural ventilation then each room shall additionally be fitted with such appliances for ventilation as shall secure to each patient in said room at least 2,400 cubic feet of fresh air per hour," etc. etc.

"The ventilation requirements as set forth in the preceding ordinance are to a large extent a dead letter, by reason of the fact that it is impossible during cold weather to obtain 2,400 cubic feet of air per hour with the windows as provided in the first part of the section referred to; in fact it is impossible to do this with safety and comfort no matter how many windows are provided. Public opinion does not at the present time countenance the enforcement of the provisions requiring mechanical ventilation in hospitals.

"When modern hospital management has reached a point where it gives as much thought and study to the air conditions maintained in a hospital as it does to the practice of asepsis, personal hygiene, diatetics and other preventive and therapeutic measures we will have provisions in every properly designed institution for maintaining the correct wet bulb temperature and for supplying the proper amount of clean air. The cubic foot of air space per occupant will then be governed largely by economic or esthetic considerations."

Should Have Ordinary Air Conditions

Dr. C.-E. A. Winslow, professor of public health, Yale University School of Medicine, considers from two viewpoints the cubic air space in hospitals: maintenance of ordinary atmospheric conditions and prevention of direct spread of infection. "It is clear from all the work of recent years that the essential thing is the maintenance of a temperature not above 68° with a moderate but not excessive air movement," says Dr. Winslow. The cubic space from this standpoint is a problem of very minor importance, as no one would, I imagine, today dream of crowding hospital patients so closely together that the heat produced by the vital processes could not be removed by the necessary air change.

"The other question is the question of the direct spread of communicable disease from bed to bed, and from this standpoint the army experience showed that the placing of beds too close together was of very distinct importance. The frequency with which carriers of hemolytic streptococci and other possibly dangerous mouth bacteria are found makes it necessary to observe the general principles that were worked out in the army hospitals in England and this country during the war."

Sees Many Contributing Factors

Air space per patient can best be decided in relation to humidity, temperature control and air replacement, according to **J. Howard Beard**, professor of hygiene at the University of Illinois.

"The mathematics of cubic air space per patient in hospital wards," he declares, "is inextricably associated with cost of construction, administrative efficiency, temperature, humidity, air motion and cross-infection in its widest sense. With so many factors operative, the air space to be allotted to each patient may best be decided after determination of the facilities provided to insure humidity, temperature-control and air replacement. Eight hundred cubic feet per patient with adequate arrangement for provision of moisture, air exchange and temperature fluctuation is preferable to 1,200 cubic feet without the presence of these conditions in proper proportion.

"The cubic air space of a ward is also influenced by the closeness of the beds and range of droplet infection. While disease may be air-transmitted for a considerable distance under extraordinary conditions, the great danger zone is usually limited to four or five feet. This means locating beds about eight feet from center to center. Where they are placed on both sides of the ward, an eight foot aisle would be in the interest of the efficient care of the ward and of the patient.

"The average hospital bed is six feet six inches long. If one foot six inches is allowed for space between head of bed and wall, eight feet from center of one to that of another, and an eight foot aisle between rows of beds, each will require ninety-six square feet of floor space and about twelve hundred cubic feet (1,152) if the ceiling is twelve feet high.

"I should be inclined to favor a large rather than a minimum cubic space, because, other things being equal, the air is more likely to be healthful. It would give an elasticity to the ward in case of emergency. It would tend to limit cross-infection of communicable disease, usually not treated in isolation. It would facilitate care of the

*Jour. Am. Soc. Heat. & Vent. Engineers, xix, i, 1-14 (Jan., 1919); also THE NATION'S HEALTH, Vol. iii, No. 10, Oct. 15, 1921, pp. 577-581.

patients and of the ward; it is particularly desirable where it is used for bedside teaching of medical students."

Thinks Temperature Is the Thing

Room temperature is the big thing in ward ventilation is the opinion of **Dr. George T. Palmer**, epidemiologist of the Detroit Board of Health. With the room temperature correct, humidity need not be so carefully considered.

"It is the distance between beds in hospital wards which should largely determine the space requirements," says Dr. Palmer. "Allowing ample aisle space and four feet between beds there would be required about 100 square feet per bed. With twelve-foot ceilings this would give a cubic space allotment per bed of 1,200 feet. This would be a desirable arrangement. Some of the tables shown in text books call for from 600 to 1,200 cubic feet. The object of adequate spacing between beds is to prevent patients from coughing in each other's faces and from disturbing one another.

"Still more important than the cubic space is room temperature. Hospital wards can be adequately ventilated from the windows by placing radiators beneath the windows and deflectors at the windows. The deflector and the rising heat will direct incoming air upward. Except in those special cases where cool air may be contra-indicated, such as with nephritis, the room temperature may well be kept within the range of 62 to 68. It is my personal feeling that at these temperatures it matters little as to the humidity. In the wards for infants somewhat higher temperatures will probably be necessary. With very young infants, where temperatures around 80 are needed, the humidity question is of more importance. Here we should probably find by experiment that the addition of moisture up to 50 per cent relative humidity would be better than humidity around 20 per cent.

"From personal observations made in the wards of Walter Reed Hospital in 1918, where the square feet of floor space averaged 60 and the air space 700 cubic feet per person, there was ample air flushing, comparative freedom from dust and frequent overheating. In other words, the temperature factor was more open to criticism than any other. Carbon dioxide averaged less than 6.5 parts per 10,000, temperature, 69. There were many instances of temperature rising above 75°. The close, stuffy room is an overheated room. Lower the temperature below 70 degrees and the stuffiness automatically vanishes. The cause of the overheating was not the lack of open windows, but the failure to close the steam radiators. Every hospital ward should have large, readily visible thermometers. This is the most important yard stick with which to measure ventilation."

1,000 Cubic Feet Is Minimum

Dr. Mazyck P. Ravenel, professor of preventive medicine, University of Missouri, would place 1,000 cubic feet of air space per person as an absolute minimum, with 2,000 cubic feet as desirable. So many factors contribute to the determination of the exact space, that no positive statement can be made, he declares. Of the factors to be considered, Dr. Ravenel says:

"The question of ventilation is largely one of heat removal and regulation of moisture. While an excessive amount of CO_2 or a deficiency of O is not permissible, these factors do not play a large part in ordinary rooms. In order to attain the objectives mentioned, without discomfort to the patient, there should be a minimum of 1,000 cubic feet of space for each person, with a floor space not less than 80 square feet. These are the minimum requirements, and it is far better to have as much as 2,000 cubic feet of space for each patient. So much depends upon the shape of the room, the system of ventilation, the system of heating and the efficient management of these systems, that it is difficult to make positive statements as to the exact space required. We should err on the safe side and give an excess of space rather than too little.

An Architect's Viewpoint

An architect's conception of the debatable problem of air space cubage, temperature and humidity required for the ward patient is given in the following statement made in this symposium by **Richard Resler** of the firm, Resler & Hesselbach, architectural and consulting engineers of New York.

"All wards as a rule have windows on both sides and end which, due to prevailing winds, induce cross ventilation. The windows should begin at the ceiling and extend down to as near the floor as possible, having transoms at the top with draft boards on the sides of transom sash and a draft board at the bottom of the window which will deflect the air currents upward. The radiators should be located under the window sills. Thorough consideration, of course, must be given the surrounding buildings, sunlight exposure and prevailing winds.

"As to the cubage of air space required per person in an open ward medical authorities differ. A space of five feet between the beds and a ceiling height of twelve feet (which appears ample in view of the fact that the breathing height in bed is three feet) would give a cubage of approximately 1,400 cubic feet, although there is no basis for this assumption except to maintain an eight-foot danger zone about the patient.

"Here again, in actual practice, this cubage will be increased or reduced due to the census fluctuation inherent in a hospital. The actual cubage in an overload would amount to about 1,200 cubic feet.

"Natural cross ventilation for wards attained by the proper location and design of windows, assuming that the proximity of adjacent buildings is not a menace, and a minimum air space cubage for ward patients of 1,200 cubic feet appears logical."

Prefers Natural Ventilation

Natural ventilation, rather than any artificial arrangement, is also found preferable by **William D. Crow** of the New York firm of architects, Crow, Lewis & Wick. Regarding cubic air space per patient, Mr. Crow asserts:

"We do not think that the number of cubic feet of air per person in any hospital unit is of much importance, after a certain reasonable minimum has been provided or exceeded, just as would be proper in any other space intended for human occupancy. We have seen a great deal of specific data as to the volume of air which should be provided for each patient but none of it has convinced us that the matter is removed from the necessity of using common sense and experience rather than mensuration.

"No one would think of providing air-tight spaces for patients, in which they would be confined without further air supply, even if several thousand feet of air were provided for each patient. Ventilated spaces are the alternatives, and as these are passages for air, so long as the ventilation is maintained, it does not seem vital that the spaces should be a few hundred feet more or less in volume."

ADMINISTRATIVE RECORDS FOR THE HOSPITAL*

THE report submitted by the Committee on Forms and Records of the American Hospital Association at the 1921 convention was presented with the idea of furnishing definite data that could be used as a basis in establishing more uniform methods of recording the various activities of our institutions and of thus rendering hospital statistics of all kinds more readily comparable.

A number of basic principles were enumerated. The scope of the report and the time occupied in presentation prevented any extensive discussion of its contents at the convention. For this reason, because of the nature of many inquiries and to recall attention to the subject, a series of four papers (of which this is the first) has been prepared. While these articles will be explanatory in nature they should also be considered in connection with the report inasmuch as frequent reference will be made to its contents.

Under Division C of the report a group of records were included which for lack of a better term were designated as Administrative.

The records outlined under this heading are necessary in order to provide a basis for computing the amount of work done by the institution, for correlating financial, vital and professional records and consequently for the determination (in part) of the per capita per day cost.

Admitting Service Records

Under Admitting Service were grouped those records that have to do with the patient's admission to the institution. The information concerning this phase of work is necessary for medico-legal purposes and is often the starting point for social service work.

The records made should indicate the method of approach to the institution, whether by previous reservation of accommodations, because of some emergency, etc. They should further detail the admission to the hospital, assignment to hospital and professional division, noting legal commitment, etc., and the method of caring for the patient's effects, such as clothing and valuable papers.

The records made should indicate the method of approach to the institution, whether by previous reservation of accommodations, because of some emergency, etc. They should further detail the admission to the hospital, assignment to hospital and professional division, noting legal commitment, etc., and the method of caring for the patient's effects, such as clothing and valuable papers.

The records pertaining to the discharge of any patient should portray in brief form the facts that the professional records are complete; that the "follow up" has been originated; in case of release, that the commitment has been satisfied; or in case of removal against advice, that all responsible parties are informed of the circumstances. They should show that the patient's effects have all been returned or are properly accounted for; that his financial obligations have been satisfactorily adjusted. In the event of death, the records should show what effort, if any, has been made to secure a post-mortem examination; that the official death certificate has been originated and filed with the proper authority; and that the disposition of the body has been made upon the order of some responsible individual.

The records included under Information Service are of the utmost importance for they furnish the basis for contact between the hospital and the relatives and friends of the patient. They need not be extensive but should in every instance be accurate. They should furnish the information clerk promptly and continuously with such data as will enable her to establish sympathetic and cordial relations with those inquiring concerning the patient's condition and progress. Careful attention to this service, in order to keep it at the highest level of efficiency, is one of the best methods of establishing favorable recognition by the public available to the institution.

Another equally important service is that having to do with the admission of visitors to patients. We are of the opinion that the institution's policy toward visitors should be a liberal one because it is one method of popularizing the institution, but we believe that a definite mechanism of control should be provided in order that abuses may be restricted to a minimum and that no harm result to any patient.

Some General Service Records

Under the heading of General Service are grouped a number of records, chiefly temporary in type, that concern procedures not readily assignable to other divisions. Among these are the following:

Internal transfer of patients: A brief temporary record of the transfer of the patient from one hospital or professional division to another is essential for the purpose of furnishing prompt data to information clerk, bookkeeper, dietitian and other department heads interested.

Ward census: This record is a most important one and should be returned at a specific hour each day. Its correctness must be verified daily and certain data should promptly be posted to the more permanent records. This record should be made in order that the administrator and all others concerned may have accurate and reliable information concerning the population of the hospital, and that it may serve as a basis for reservations and assignment of patients admitted. It is the basis upon which the number of "days' hospital care" or "days' treatment given" is compiled and it is therefore an essential record in the financial department.

The formula cited on page 15, under C-4-B, is in very general use and is well adapted to the purpose. It will be discussed in greater detail in a subsequent paper.

Employment and employes record: It is probably not essential that this record be maintained. Hospitals are finding, however, that in order to develop and retain an efficient working personnel, it is necessary to pay more attention to the selection of employes and the manner in which they perform their duties. Brief records concerning them are therefore very desirable. These furnish a means of ready reference when inquiries concerning former employes are received and also furnish a definite basis upon which policies toward individual members of the organization may be developed.

Attending and house staff register: This is also a non-essential but highly desirable record. It furnishes a means of checking the attendance of staff members and is frequently referred to when inquiries concerning them are received, and in many other ways has been found of great assistance in many institutions.

*This article prepared by A. C. Bachmeyer, M.D., F. E. Chapman, and John Bresnahan, M.D., is the first of a series of four which will appear in succeeding issues of THE MODERN HOSPITAL, supplementing and interpreting the report of the Committee on Hospital Forms and Records which was made at the twenty-third annual meeting of the American Hospital Association in September, 1921.

Operating room schedule and reservation: This is another "non-essential" record, but particularly in those institutions where surgical work predominates and where a number of surgeons are being served, it has been found a very helpful means of avoiding difficulties among members of the professional staff.

Medical Record Service

Under the heading of Medical Record Service there are included several forms. Primarily an alphabetical index to patients' names, diagnosis and complication, and follow-up cards. These records should not be confused with those set up under Professional Service.

It is not intended that the alphabetical index to patients' names referred to here be duplicated elsewhere in the general offices. But whether the professional records are filed by admission or discharge number or by classification of diagnosis, an alphabetical index to patients' names will be necessary as a key to those files.

Diagnosis and complication cards will provide better access to the professional records for purposes of research and study. Many institutions have been keeping records of professional performance for many years, but have filed those records in so inaccessible a manner that physicians and surgeons have found it to be almost impossible to get at them. The lack of a uniform or standard nomenclature and classification of diseases has also militated against the use of many of our professional records. The tendency at present is toward more frequent reference to this data and it is to be hoped that considerable progress in methods of classification, nomenclature and filing will be made so as to make use of the vast amount of recorded experience in the diagnosis and treatment of disease confined in these records. They may also be used to improve the statistics concerning morbidity thus furnishing public health workers with more reliable data.

Reference has not been made except in one instance to any particular form of chart or card. Samples of practical forms to cover any particular phase of work, which are now in use in many instances, accompanied the report.

It is not argued that those particular forms are best for the purpose or that they will apply in all instances, but they are submitted with the hope that because they offer a more uniform method of recording data they will come into general use and that, if uniform methods of recording information are used, the statistics compiled from such data will be more comparable and of greater use to all hospitals.

TUBERCULOSIS SCHOOL AT OTEEN

A tuberculosis school similar to that held last year was conducted by the U. S. Public Health Service from June 1 to 30 at the government sanatorium in Oteen, N. C. The class consisted of thirty medical officers and thirty nurses, drawn for the most part from other service hospitals. A few others identified with tuberculosis work in different parts of the country, although not employed by the government, were admitted.

The first school, which graduated twenty-two physicians and nineteen nurses who had been carefully selected from the sixty-six hospitals of the Service, was patterned after the summer school at Saranac Lake, N. Y., with necessary adaptations to the special work required.

Oteen Hospital, with a capacity of 1,100 beds, is near Asheville, N. C., and is conducted especially for tuberculosis patients. This delightfully situated and easily accessible sanatorium was built during the war by the Army and was later turned over to the Public Health Service. It is in close proximity to the Public Health Service Hospital at Biltmore.

DENTAL CLINICS IN HOSPITALS AND DISPENSARIES*

1. Dental service is an essential part of the work of a general hospital, as an element in complete diagnosis, and as a treatment need of many patients.

2. A dentist competent as a dental diagnostician should be recognized with adequate rank on the staff of the hospital, and should be given the necessary facilities, such as access to the x-ray and to beds when necessary.

3. The primary responsibility of the hospital in dental care is the dental diagnosis of patients whose mouth conditions are involved as a factor in the disease for which the hospital accepted these cases, and for whom dental treatment is necessary in order that the hospital's medical or surgical work shall attain satisfactory results. In other words, a hospital cannot carry out adequate diagnosis and treatment without undertaking dental diagnosis, and in some instances dental treatment also.

4. A routine dental examination of hospital cases should be included as part of the physical examination.

5. Hospitals maintaining out-patient departments should include a dental clinic for treatment purposes as part of this out-patient department, unless by some definite affiliation with another accessible dental clinic the necessary dental care of its patients can be assured.

6. The service of a dental clinic as part of the hospital out-patient department must ordinarily be limited in order to avoid over-crowding. Patients should be accepted for treatment in the following order:

a. Patients already received by the hospital or dispensary, whose mouth conditions are involved in a general medical or surgical condition which the hospital or dispensary has diagnosed, and for which it has assumed responsibility for treatment.

To give dental care to these patients or to arrange for their care by definite reference and follow-up to some other institution is a responsibility which every hospital ought to meet.

b. Patients referred to the dental clinic from other medical or community agencies (such as a doctor or the visiting nursing organization) with the indication that the dental conditions are involved in the general condition of the patient.

c. Relief of pain and other emergency dental work for patients not otherwise connected with the hospital, but accepted merely as emergency cases.

d. Other patients accepted up to whatever number may be consistent with the facilities. So far as possible, this restriction should be on a district basis.

7. Dental organization in the hospital.

a. The dentist recognized as head of the dental service of the hospital should be in charge of the organization of its dental work, including the out-patient clinic.

b. Assistant dentists are desirable as visiting members of the staff of the dental clinic.

c. A dental intern is desirable, as a member of the staff of the hospital. His work cannot be confined primarily to assisting in the therapeutic work of the out-patient department, but he should be given opportunity to work in the diagnostic service with the chief of the hospital department, in order that his year of internship shall be a year of advanced dental education in both curative and diagnostic work. The supply of dental interns is inadequate, but the trend of dental education will stimulate young graduates to a hospital year, and the increasing demand for dental service in hospitals may be expected to increase also the facilities which hospitals will offer.

d. The dental hygienist is a desirable member of the staff of the dental clinic, and as an agent for cleaning the teeth of bed patients in the hospital.

e. Salaries for visiting dentists are generally necessary.

f. The dental clinic should charge fees covering cost of treatment, remitted, however, if the patients are unable to pay.

*An appendix to the report of survey conducted in Chicago by Michael M. Davis, Jr., on Community Dental Service.

Health lies in labor and there is no royal road to it except through toil.—Wendell Phillips.

SUPPLANTING THE MEDICINE MAN*

By ARTHUR E. MIDDLETON, Chief of Construction Section, Indian Bureau, Interior Department, Washington, D. C.

NOT so long ago that the period and conditions are reminiscent or unfamiliar to those individuals who have aided and are still aiding in the moral, spiritual and physical advancement and perpetuation of the Red Man, the fight against disease was waged under the most trying disadvantages.

Then the Indian had just begun reluctantly and doubtfully to yield to the influences of civilization and, though accepting some of its customs, still clung with tenacious hold to the ideas and habits formed in the early history of the race and regarded with mingled skepticism, contempt and fear the white man's methods of healing the sick. When disease came upon him he stoically bore its pains and rigors and following the tribal custom would lie patiently upon his blanket while the "Medicine Man" with grotesque mask and weird incantations essayed to drive out the "Evil Spirit."

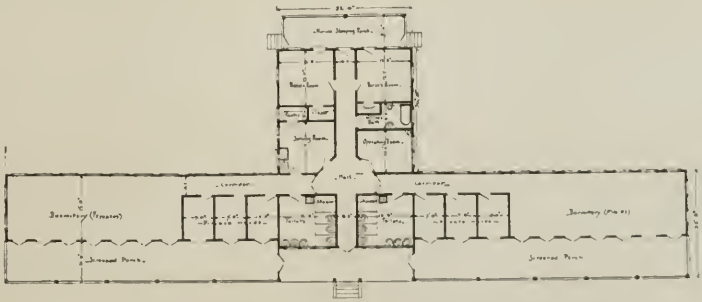
Indian girls' dormitory. East Farm Sanatorium, Phoenix, Ariz.

In a few short years, however, the government by a well directed policy has changed the medicine man's influence to a gradually lessening potentiality, and now the Indian stricken by sickness looks up from his bed in a modernly equipped hospital to see in place of the medicine man a solicitous and skilled physician and a neatly garbed nurse, who with words and smiles of encouragement, administer the treatment intended to restore him to his former vigorous health.

In 1888 there were but four buildings in the Indian Service designed solely for hospital purposes, but the years intervening between that year and the present have witnessed a rapid increase in the number of hospitals and a widening of their scope until now there are in operation eighty-nine hospitals and sanatoriums located, with several exceptions, in the vast region extending from the Mississippi River to the Pacific Ocean and from the Gulf of Mexico to the Canadian border. The exception referred to are the hospitals located at Carlisle, Pa., Cherokee, N. C., Mount Pleasant, Mich., Hayward, Keshena and Oneida, Wis.†

The school hospitals are designed solely for the treatment of children and the typical plan usually provides two separate wards for the sexes with screened and glazed porches adjunct thereto, convalescent ward. operating, waiting, nurses', dining, bath and toilet rooms and kitchen. At some of the larger schools, however, isolation and private wards and disinfecting rooms are provided. The agency hospitals while including the general plan, arrangement and scope characterizing the school hospitals are not all designed for the administration of the same activities; at the majority general cases are treated, but several are arranged for the treatment of tuberculous cases also, are supplemented with physicians' and employes' cottages, laundry and other adjunct buildings, and in some instances with separate cottages or so called "tent quarters" for the treatment of families and individuals.

The basic consideration determining the size of the agency hospitals and sanatoriums is essentially that of the prevalence of diseases in the various tribal populations while that of the school hospitals is based upon the number of pupils. The final determining considerations of all, however, are the proposed locations and amount of money available; two factors which arbitrarily fix the cost and



Floor plan of the Indian Tuberculosis Sanatorium at Phoenix, Arizona.

*Mr. Middleton's article is being published in two installments of which this, dealing with sanatoriums, is the first. Part II will appear in a succeeding issue.

†The general activities and operations of these hospitals and sanatoriums are administered by a field staff consisting of a chief medical supervisor, a supervisor of hospitals and two special supervisors; the immediate activities are directed by a resident physician at each hospital or sanatorium. All, however, are controlled and directed by the Bureau of Indian Affairs at Washington, D. C.

capacity of the buildings, the former frequently entailing extremely high rates for skilled and other labor, and the latter compelling the use to a large extent of local building materials in order to keep the expense of freight transportation to the minimum. There is present, therefore, a wide variation in the selection of the materials and in the capacities, those at the schools accommodating from six to twenty beds and those at the agencies and sanatoriums from twenty to sixty. The materials used are frame, stone, brick, concrete, adobe or a combination of them. By reason of the many differences contrasting the Indian from the white race, the monetary paucity and isolated locations, conditions must be considered in designing Indian hospitals vastly different from those which influence the designing of municipal hospitals. Therefore as models of designs in orthodox architectural styles it is obvious that, with the possible exception of a small number, the buildings may not hold up under critical technical scrutiny, but as examples of the results accomplished in the face of the handicaps cited, the majority of them are interesting examples of economical but substantial construction, inoffensive appearance and utilitarian purpose. There are, however, many points along the general trend of treatment, particularly in plan arrangement, scope of activities and details of construction in the sanatoriums and the larger agency hospitals which will draw the interest of architects called upon to design buildings and plants for municipal and private interests.

Have Been Economically Constructed

It is the purpose of this article to treat more fully of the sanatoriums and agency hospitals than of those at the schools, but it is believed that the inclusion of some of the larger and comparatively more recent hospitals at the schools will prove of more than passing interest, and with this consideration in view, the hospitals at Riverside, Cal., Salem, Ore., and Wahpeton, N. D., are selected as the best examples.

Of the agency hospitals, those at the Rosebud Agency, S. D., Kiowa Agency, Okla., and Navajo Agency, Ariz., have been selected for particular reference; and of the sanatoriums the Choctaw-Chickasaw, Okla., Canton, S. D., and the Phoenix, Ariz., plants are presented as the most interesting examples.

The majority of the buildings have been constructed under contract but there are places where local conditions and the small amount of available funds made contract work prohibitive. In these instances the hospitals were constructed in the open market with excellent result as to plan arrangement, economy in construction, good workmanship and material, and attractive appearance. As a typical example of such methods the hospital at the Cherokee School, N. C., and that at Moqui, Ariz., and the agency hospital at Fort Defiance, Navajo Agency, are selected. The Cherokee building cost $5,000 complete with all equipment; that at Moqui $14,000 and that at Fort Defiance $12,600 or six, fourteen and ten cents per cubic foot respectively, which are rather remarkable economic construction achievements, considering the remote location of the hospitals from trade centers and railroads.

The Infirmary at East Farm Sanatorium.

One of the bungalows at East Farm Sanatorium.

The sanatorium plants present a marked dissimilarity in their scope. Some are built from standardized drawings and are limited to a main building; these are usually situated near a school or agency plant within comparative easy service of activities not provided for in the main building. Where located at isolated places they are provided, as heretofore noted for some of the agency hospitals, with a number of adjunct buildings for the housing of the physicians, employes, for laundry purposes and other necessary activities. The larger sanatoriums, however, are of much greater magnitude, occupying extensive sites, and the complement and size of buildings vary with the character and number of activities administered. The sanatoriums built from standardized drawings are designed solely for the treatment of the great white plague, to the ravages of which the Indian is sadly susceptible, and are located respectively at the Cheyenne and Arapaho Agency, Okla., Turtle Mountain, N. D., Blackfeet, Mont., Pima, Ariz., Carson, Nev., Mescalero and Laguna, N. M. Those built from special drawings prepared to suit the conditions at each place are located at Spokane, Wash., Fort Lapwai, Idaho, Toledo, Iowa, Canton, S. D., Phoenix, Ariz., and Talihina, Okla.

The Standardized Sanatoriums

The standardized sanatoriums are of frame construction (with the exception of that at Laguna which is built of adobe), have a capacity of twenty patients, and cost complete including operative equipment $17,500 each. All are heated by steam and lighted by electricity, except those at Blackfeet and Laguna which are lighted respectively by acetylene gas and oil lamps. Materials and workmanship are the best of their respective kinds. The rooms are finished with hard wall plaster and metal ceilings, and the plumbing, heating and lighting equipment are designed with the special view of their suitability to sanatorium purposes. The superstructure rests on concrete foundations. Exterior walls are sheathed and finished with drop siding and the roofs are covered with heavy asbestos roofing. In the extremely cold climates the exterior walls are back plastered. Special thought has been given to the ventilation scheme, that for the wards being

U. S. Indian Sanatorium at Carson, Nev., illustrating a standardized design much in use in hospitals of the Indian Bureau.

adopted from the tuberculosis sanatorium near Denver, Colo.

For the Choctaw-Chickasaw Sanatorium nature has provided most bounteously. Placed on a broad plateau sloping to the east from Buffalo Mountain's protecting barrier amid a setting of virgin pines and oaks, the sanatorium occupies a site where attributes of scenery not only gratify the eye but where the pine-scented mountain air provides a health-giving tonic to the patients. As originally designed the plant comprised a main building located on made terraces at the northern end of the plateau facing south and approached from the main entrance gate by a broad roadway; on the eastern and western borders of the road were located separate tent quarters for men and women, bath and toilet houses, laundry and physicians' residence. This grouping and terracing plan, however, was not carried out, for the appropriation of $50,000 proved sufficient only for the main building and modified heating, lighting, water and sewer systems, and necessitated a restudy of the first scheme of the layout. The original site was retained for the main building and the power house placed at its rear on the south bank of Rock Creek from which water is pumped for fire and general service. Pure water in unlimited abundance is piped from constantly flowing springs on the upper ledges of Buffalo Mountain and supplied by gravity to the building for drinking and other purposes for which the creek water is not suitable.

In the power house there are located in addition to the pumping plant the central heating and electric lighting plants. Besides the main building, the plant comprises a superintendent's cottage, school house, laundry building, ice making plant, stable and several minor adjunct buildings. The contract price for the main building was $34,250 exclusive of administrative and operative equipments, and these are thoroughly modern and adequate for the treatment of both tuberculous and general cases, for which the building was designed.

Interior of Choctaw-Chickasaw

This building is thoroughly modern in every detail of construction and in plumbing, heating and lighting equipments follows the best known methods. The large wards are lighted by semi-indirect fixtures and the operating room by fixtures particularly adapted to the uses of that room. An electric light signalling system has also been installed in the building. The heating is by a low pressure gravity return system connected to the plant in the power house, and the radiators are the usual open section hospital type. The plumbing fixtures are of the highest sanitary type and manufacture required by the U. S. Government standard specifications and the piping installation conforms to the most modern practices. Sewage disposal is secured by a trunk line 1,500 feet long extending from the main building to a septic tank, the effluent from which is discharged into a marshy stretch of ground located 2,000 feet on the low levels bordering a tributary branch to Rock Creek.

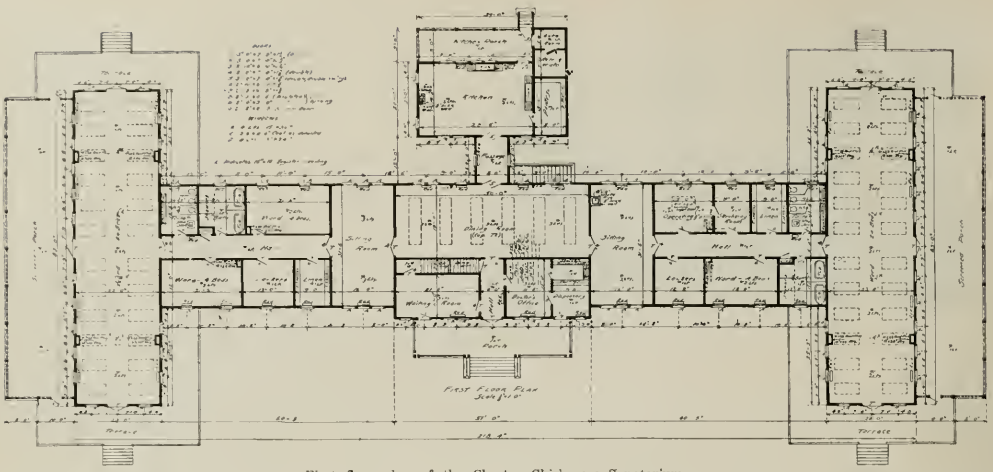
The standing finish is of pine without mouldings; doors are of the single panel hospital type; all wood floors are doubled and sound deadened in the central pavilion; and the finished flooring is of selected southern yellow pine. The walks are finished with two-coat hard plaster on metal lathing, except in the kitchen, operating, bath and toilet rooms, which are wainscoted with a stainless white cement blocked to represent tiling. These rooms have cement floors also. All rooms have metal ceilings and cornices and the roofs are covered with metal shingles. The painting is three-coat work best white lead and oil and the floors have oil finish. Ventilation is secured by natural draft through flues connected to ventilators of the air siphon type by ducts in the loft. Garbage disposal is by means of an incinerator, the heat from which is used in heating water for various purposes.

Plan of Phoenix Sanatorium

The site occupied by the sanatorium at Phoenix, Ariz., does not possess the diversity of mountain scenery and natural arboreal wealth found at the Choctaw-Chickasaw site, but by the introduction of irrigation and planting schemes the site has been transformed into a very pleasing one. The plant consists of a main building, infirmary, medical laboratory, assembly hall, dining hall, employes' club building, physicians' residence, several employes' cottages, bath house, laundry, power house, warehouse, barns and twenty-four bungalows or tent quarters.

The main buildings are grouped around three sides of a rectangle, 432 feet long by 336 feet wide, in the center of which the tent quarters are arranged in two groups of twelve bungalows each, placed on either side of a campus 50 feet wide; each group is separated by a street 24 feet wide, the bungalows being placed 24 feet apart and approached by cement sidewalks. The bungalows are 12 by 14 feet, of frame construction resting on concrete piers two feet above the ground and are finished with drop siding up to a height of four feet, above which the space is enclosed with wire screening three feet high and canvas

A typical ward in the Carson Indian Sanatorium.



First floor plan of the Choctow-Chickasaw Sanatorium.

curtains on rollers. They are heated by stoves and cost $350 each.

The main building is designed for the treatment of incipient and moderately advanced cases, is of frame construction, lighted by electricity and will be heated by steam. The cost complete with operative equipment was $14,500. A structural feature worthy of special mention are the open wards which take up most of the floor space in the second story. These are enclosed with wire screening and heavy canvas curtains on rollers; the floors are covered with a steam-boat deck covering consisting of 12-oz. canvas on 1¼-inch narrow-tongued and grooved flooring over heavy waterproof building paper; they are painted four coats of lead and oil. The interior finish, painting, plumbing, heating and lighting equipment are similar to those items described for the infirmary building.

This building is designed for the treatment of advanced cases and was completed in 1918 under contract at a cost of $9,305 exclusive of operative equipment. The superstructure is of full frame construction resting on concrete foundations; the exterior walls are sheathed and covered with three-member rustic clear redwood siding and the roofs are covered with composition material. The exterior and interior woodwork is of clear pine, the door and window trims being plain and finished on the exterior with drip caps. All bases are plain and the walls and ceiling are finished with hard plaster in two coats; the wood work is finished with three coats of best grade white enamel. The plumbing equipment is of the very best grade hospital type and hot water is supplied from the circulation system in the power house. The building is lighted by electricity and will be heated by steam similarly to the main building, both installations following the most approved methods suitable for hospitals.

The installations are connected up to the central systems in the power house, that for the steam being of the two-pipe vacuum type. The plant is also provided with a modern sewer system forming part of the extensive system recently installed at the boarding school and connected up to the city system at Phoenix, Ariz.

A view of Choctow-Chickasaw Sanatorium at Talihina, Okla.

COOPERATION IN RELIEF WORK

Here is the story of a sick man who hurts the cause of the sick, as related by the Detroit department of Health in its *Weekly Health Review*:

Herman Kiefer Hospital opened her tuberculosis ward to him early in 1918. He stayed several months and then left without permission. He found it more to his liking to enlist the sympathy and financial support of private individuals. He asked for money to take him west so he could be cured of tuberculosis. He got it —got it many times and he abused the kindness of the people who helped him.

Individualistic philanthropy did this since 1918:—

It sent him to Colorado and return three times; it sent him to Illinois and return three times; it sent him to Minnesota once and to Iowa once; it helped him into Eloise, Herman Kiefer and the Detroit Tuberculosis Sanatorium about ten different times.

Last year Detroit business men gave him $486 in three months.

The last we know he had a letter from a physician stating that the bearer had tuberculosis and if given financial assistance would go to the west to live.

It is not economical to dissipate the helping dollar. There are many people who need it and who will be square in their use of it.

The way to connect the helping dollar with these people is to pass relief cases through a clearing house. Detroit possesses such a clearing house in its department of public welfare.

NEW YORK AS A HOSPITAL CENTER

By E. H. LEWINSKI-CORWIN, Executive Secretary, Public Health Committee, New York Academy of Medicine, New York

According to the figures published by the American Medical Association, about ten per cent of all the hospital beds in the country and about twenty per cent of the hospital facilities of fifty larger American cities are located within the boundaries of the city of New York

There are in New York City about 32,000 hospital beds; the investment in real estate alone amounts to eighty million dollars and the annual maintenance costs total thirty-five million dollars.

As a phase of the educational activities which the New York Academy of Medicine is carrying on, the public health committee of the academy made a survey of the hospitals of the city. The field covered in the survey can perhaps be best visualized by the following general outline of the study.

Scope and Method of Study

I. Historical account of hospital development in New York City.
   a. Phases of institutional development.
   b. The development of legislation relating to hospitals and the care of the sick.
II. Hospital facilities in New York City.
   Distribution of bed capacity by:
   a. Boroughs.
   b. Ownership of hospitals.
   c. Capital investment.
   d. Size of institutions.
   e. Type of service.
   f. Private, semi-private and ward services.
   g. Medical affiliations.
   h. Ambulance areas.
III. The problem of illness.
   1. The prevalence of illness.
   2. Hospitalization.
   3. Hospital charges for:
      a. Ward accommodations, private and semi-private accommodations;
      b. Laboratory, x-ray and other charges to ward and private patients.
   4. Income in relation to illness.
IV. The economics of hospitals.
   1. The sources of income.
   2. Costs of maintenance.
   3. Endowments.
   4. Workmen's compensation.
   5. Social policy.
V. Hospital administration.
   1. Organization of responsibility.
   2. Control of personnel and procedures.
   3. Methods of purchasing and of food control.
   4. Cost accounting.
   5. Equipment.
   6. Measures of efficiency.
VI. Medical organization.
   1. Forms of organization.
   2. Control of medical and surgical procedures.
   3. Teaching and research.
   4. Efficiency tests.
   5. Control of interns.
   6. Case records.
      a. Forms.
      b. Fullness and accuracy of reporting.
      c. Methods of filing.
      d. Availability.
   7. Retiring age of attending staff.
VII. Nursing staff.
   1. The supply of nurses in hospitals.
   2. Training schools.
      a. Standards.
      b. Teaching methods.
      c. Student body.
   3. Amount of nursing care in the hospitals.
   4. Discussion of problems.
VIII. Hospital personnel.
   1. Laboratory and technical departments.
   2. Administrative:
      a. Executive.
      b. Departmental.
   3. Compensation of hospital employes.
IX. Study of case records.
   1. Comparative analysis by procedures.
   2. Comparative analysis by conditions.
X. Provisions for chronics and convalescents.
   1. The medical and economic consideration of the problem.
   2. The extent and type of facilities for the care of chronic conditions.
   3. The extent and type of facilities for convalescent patients.
   4. Special needs.
XI. Special problems.
   1. Teaching and research.
   2. Occupational therapy.
   3. Dietetics.
   4. Social service.
   5. Districting of the city for hospital purposes.
   6. Special hospitals for infants and children.
   7. Special hospitals generally.
   8. Problem of tuberculosis.
   9. Problem of venereal disease.
   10. Problem of the crippled.
XII. Community policy with regard to hospitals.

It will be seen from the above outline that there is hardly a phase of hospital organization and work which has not been taken up, with the exception of the out-patient departments which were a subject of special study on the part of the committee prior to that of the hospital study.

A survey of this kind is apt to reveal prevailing conditions and procedures; that is its chief function and value. Surveys have been likened to stock-taking in the industrial and commercial world and have become recognized as an indispensable phase in the social bookkeeping of our democracy.

It is impossible in a brief summary to even enumerate the main findings. Only certain aspects will be touched upon here.*

Main Findings of Survey

It would perhaps be of interest to point out that 57 per cent of the hospital beds in the city are in privately endowed institutions, 39 per cent are in municipal or public institutions and about four per cent in private sanatoriums.

More than one-half of all the hospital beds are in the Borough of Manhattan.

Fifty-eight per cent of all the hospital beds in New York City are in general hospitals, 38 per cent in special hospitals and four per cent in the proprietary sanatoriums. Of the 18,400 beds in general hospitals, 34.5 per cent are in hospitals of over 500 bed capacity; the majority of these are in municipal institutions; 33.5 per cent are in hospitals of from 250 to 500 bed capacity; about 22.5 per cent are in hospitals of 100 to 250 bed capacity; about eight per cent are in hospitals with a bed capacity of 50 to 100 beds; and about two per cent are in hospitals of less than 50 beds.

Of the 11,937 beds in special hospitals, 46 per cent are in hospitals of over 500 bed capacity; 23.5 per cent are in hospitals of from 250 to 500 bed capacity; 17.5 per cent are in hospitals of 100 to 250 bed capacity; 11 per cent are in hospitals of 50 to 100 bed capacity; and 2.5 per cent are in hospitals under 50 bed capacity.

As far as hospital reports are accurate, it would appear that 390,000 patients were cared for during the year 1920; 300,000 (in round figures) in general hospitals, and 90,000 in special hospitals. Six and three quarters million days of hospital care have been given during the year; four and a half million by general hospitals and two and a half million by the special hospitals.

Over 3,200 physicians and surgeons are on the visiting staffs of the hospitals in New York City and more than 6,500 nurses are engaged in the care of the sick.

One of the most interesting tables prepared on the basis of the information secured in the survey was that showing the distribution of bed capacity according to service and

*Sections of the summary of the study were published in The Modern Hospital of February, 1922, in Journal of A. M. A. of February 25, 1922, in American Journal of Nursing, May, 1922, and in Hospital Management, February, 1922.

use in the hospitals in New York City. This, I believe, is the first more or less successful attempt made to analyze the "supply curve" of hospital facilities.

The figures as given in the table below are only approximately correct and refer to the year 1920. They are reproduced here as of possible interest to other communities as well as to the city of New York.

Distribution of Bed Capacity According to Service and Use in 182 Hospitals of Greater New York

Service and Use—	Municipal Beds	Municipal Percent	Private General Beds	Private General Percent	Private Special Beds	Private Special Percent	Proprietary Beds	Proprietary Percent	Total	Total Percent
Medical	1,366	11.1	1,900	18.5	53	.7	....	....	3,319	10.6
Surgical	1,424	11.6	2,290	22.5	9	.1	....	....	3,723	10.6
Obstetrical	398	3.3	666	6.5	558	8.0	203	15.2	1,825	5.3
Gynecological	254	2.1	313	3.0	119	1.5	....	....	686	2.2
Genito-urinary	242	2.0	96	.9	....	....	....	....	338	1.0
Syphilis	211	1.8	....	....	6	.2	....	....	217	.6
Eye	117	1.0	12	.1	47	.6	....	....	176	.5
Eye, ear, nose and throat	....	....	98	.9	403	5.6	....	....	501	1.6
Pediatric	879	7.2	957	9.0	882	12.3	....	....	2,736	8.7
Orthopedic	236	1.1	70	.7	447*	6.3	....	....	753	2.4
Chronic orthopedic	....	....	....	....	556**	9.9	....	....	556	1.7
Skin	174	1.5	8	....	30	.4	....	....	212	.6
Cancer	....	....	....	....	129	1.8	....	....	129	.4
Chronic cancer	....	....	....	....	263	3.7	....	....	263	.8
Neurological	532	4.4	17	.1	349	4.9	....	....	898	2.8
Interchangeable	....	....	2,899	28.3	169	2.4	819	69.9	3,887	13.0
Psychopathic	434	3.6	....	....	350	4.9	332	24.9	1,116	4.0
Tuberculosis	2,585	21.0	16	.1	1,621	22.9	....	....	4,222	13.5
Erysipelas	33	.3	....	....	....	....	....	....	33	.1
Contagious	1,959	16.0	10	....	....	....	....	....	1,969	6.3
Chronic	1,174	9.6	....	....	458	6.5	....	....	1,632	5.2
Industrial	....	....	....	....	40	.5	....	....	40	.1
Boarding Beds	12	.1	....	....	....	....	....	....	12	....
Bassinets	283	2.3	890	8.6	555	7.9	....	....	1,728	6.0
Research	....	....	....	....	70	.9	....	....	70	.2
Total	12,331		10,242		7,124		1,354		31,051	

*Of these 273 beds are for children.
**Children's beds.

The survey likewise brought out the need of additional convalescent facilities and a better correlation of the available accommodations in this realm. Certain types of conditions are well provided for while other types, such as nervous and borderline mental cases, are not adequately considered. A study of 3,236 case records selected at random from the files of the social service departments of a group of hospitals showed that in 908 or 30 per cent of the cases there is a convalescent need. Of the 908 cases needing convalescent facilities, 23 per cent were adult males, 22 per cent adult females and 35 per cent were children under fourteen years of age. The existing ratio of accommodations between men and women does not correspond to the need as ascertained from the above analysis of records. There are inadequate facilities for men and adolescent boys as compared with women.

As has been stated above the provisions for chronic disease cases are not adequate, and with a few notable exceptions, the equipment of these institutions is meager and the amount of medical attention provided is insufficient for the need.

Very few of the general hospitals and not all of the institutions for chronic cases have utilized the opportunities offered by physio-therapy and occupational therapy.

The survey has further shown the need of larger nursing staffs in almost all of the hospitals, of more ample laboratory and x-ray facilities with adequate personnel, of the extension of the follow-up service, and a more careful and scientific supervision of the work of interns, nurses, dietitians and other professional agents of the hospital, of a greater utilization of hospital facilities for clinical research and teaching, and of more uniformity in the statistical, financial and efficiency accounting of the hospitals.

What was particularly striking as an immediate need was an agency in the city which would assemble facts concerning the work of the hospitals from year to year and which would be at all times in a position to inform the hospitals and the public as to existing conditions, immediate and future needs, and the prevailing practices and procedures. The public health committee of the New York Academy of Medicine accordingly recommended that such an agency be organized in the city. Recognizing this need the United Hospital Fund of New York established a bureau known as the Hospital Information Bureau whose purpose is to meet the need revealed by the survey.

'Ere long New York City will become one of the great medical centers of the world. It has all the elements necessary for this high destiny: vast clinical and research facilities, an abundance of medical talent and surgical skill, huge economic resources and a gradually developing spirit of community responsibility and cooperative helpfulness.

An examination of the table leads one to ask whether the provisions for certain types of conditions are adequate for the needs of the community. This would particularly apply to such conditions as those associated with the eye, ear, nose and throat, gynecology, urology, syphilis, neurology, industrial reconstruction and the care of the chronics.

The "supply curve" has no significance unless compared with the "demand curve." Unfortunately the actual or potential demands for hospital accommodations can not be determined very accurately because of the lack of morbidity statistics. With the exception of the prevalence of certain reportable diseases, we have no yardstick to gauge the problem of illness in its constituent elements. The various surveys and studies have given us a general idea as to the total amount of illness in a community but have done little more than this. With certain exceptions, such as in cases of contagious diseases, tuberculosis, and obstetrical conditions, we have not sufficient data at our disposal as yet to say accurately how many hospital beds of a certain kind a given community needs. The personal experiences of physicians and social workers in obtaining hospitalization for certain types of cases furnish some clue to the situation.

Middle Classes Need Facilities

In the light of the information which could be obtained as to this phase of the hospital situation, it would seem that the most pressing immediate need for extension of the hospital field in New York City lies in the direction of larger facilities for patients of the middle classes.

The general needs of the city as far as its own population is concerned seem to be fairly well met. New York, however, because of its medical renown, attracts a considerable number of patients from outside the city limits

THE PRACTICE OF READING ALOUD TO INVALIDS

By THEODORE DILLER, M.D., Pittsburgh, Pa.

THE practice of reading aloud may, I suppose, be designated as an old-fashioned one since it appears to be done less and less often. People are not at home nearly so much these days as they were in times gone by and now there are many diversions that lead them from their library tables and their books. Yet the practice of reading aloud has not wholly disappeared; and it would be well indeed if in the future we would see a regrowth of it.

One can read a book alone to be sure. One can travel alone. One can view nature or paintings or churches alone; but every wholesome-minded person would sometimes prefer a companion so that he may pour out his own comments upon a sympathetic ear and receive in return those of his companion.

Who has not felt in reading a book that he would like to stop and comment upon this and that statement or description or criticism of the author! So it would seem to me there is the same reason for reading aloud that there is for a companion in enjoying scenery or works of art.

For men, women or children convalescing from an illness reading aloud ought to be particularly acceptable inasmuch as it is often fatiguing for the convalescent to read himself. Moreover, a book read aloud gives the convalescent the opportunity to comment and to enjoy the book sympathetically with the reader.

The Voice of the Reader

In these days of speech making we hear many voices: in church, on the platform and in the theater besides in ordinary conversation. There are all sorts of faults to be found with voices. Some are too loud and others too low. Some are sharp or nasal; one may speak too rapidly or too slowly or mumble. I have noted a curious thing, that sometimes a great singer does not possess a pleasing conversational voice. The most beautiful voice I have ever heard came from a woman who was nearly tone deaf and unable to carry on an ordinary tune. I know some voices that are pleasing to me apart from anything they have to say, and some that are habitually displeasing. I have often heard a certain great scholar make addresses and after dinner speeches. His voice is very flat and grating to me, and yet this is a good man; he is very good man; he is very learned and talks sense.

One who reads aloud should raise his voice just high enough to be heard easily. He should read with some but not exaggerated expression, being careful to put in proper stops. Some persons can read rapidly and yet read well. The rapidity with which one reads should be gauged by his own powers of reading and the receptivity of the listener. The reader should above all aim to read with simplicity.

Some people like books, some like them very much and some care for them hardly at all. And so, in reading aloud, one should consider what to read. It is at once obvious this must depend largely upon the person read to. No very definite directions can be given. There is no particular class of literature suitable for the sick; but in a general way I feel that newspapers should not be read to invalids. It is better if even magazines are not read, but rather solid books, books of real worth. I see hardly any limit in the choice of books except the mental capacity of the hearer, a thing to which the reader should pay most careful attention. This statement ought to be somewhat qualified. It is better generally to avoid books in which the imagination is greatly displayed, as in Victor Hugo or Poe. Humorous books are often very suitable but not always. It is a mistake to make too much of a studied effort to "cheer up" the invalid. Among suitable books I name Oliver Wendell Holmes, Washington Irving, Mark Twain; and I have often recommended Jane Austen and the old standard writers—Scott, Thackeray and George Eliot. It often happens that short stories are more suitable than long ones, and these we have in abundance. Nothing is better than those of O. Henry. Myra Kelly writes amusing stories about children. The reader must not weary the convalescent and he ought to be careful to watch for this.

Favors a Society for Reading Aloud

If reading is done in the right sort of way at the right time and not too long, I think it often happens that persons who have not cared for reading before come to like it. Personally I feel the habit ought to be cultivated both by well persons and invalids. In the hospital if the patient has a trained nurse in charge she will find ample time to read to him, but without special nurse he can hardly expect the nurses to take time to read to him. Here it seems to me is a great field for useful work for women of leisure—to visit hospitals and homes regularly for the purpose of reading aloud to those who enjoy it and who would profit by it. If a sufficient number of women were banded together for this work of reading aloud all the reading that could be absorbed by invalids could be given without undue burden to any individual reader. If there were an organization in one of our large cities for reading aloud, it might be that such readers could receive instruction in the use of the voice and some hints of books to be read. I am sure that our public libraries would be ready to cooperate in this matter. It may be there is such a society in existence, if so I should like to hear something of it. It goes without saying that reading aloud should be done only with the approval of the physician in attendance.

The United States Government is conducting the largest trade and industrial school in the world. It has more than 130,738 students enrolled. This "school" is the rehabilitation division of the United States Veterans' Bureau through which the government is training these 130,738 veterans in a trade, industry, profession, business or in agriculture.

The instruction in these vocations is furnished in leading colleges, technical schools, commercial schools as well as in business establishments, shops and on farms. These men are in training in every state in the union and in every large city in the country. In all the large industrial centers these men who have received this intensive training from the government are available for positions. Every vocation is represented and any employer who needs additional personnel will be furnished such personnel from this vicinity in short time by notifying the Veterans' Bureau. Not only is this personnel trained in the best schools available but they have also received practical instruction on the job in industrial establishments and in shops.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
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NURSING EDUCATION AND THE AMERICAN HOSPITAL*

By RICHARD OLDING BEARD, M.D., University of Minnesota, Minneapolis

TO THE evolutionist who believes in an ever-evolving process, history has its chief interest in the afterglow it casts upon the present and the guidance it gives to the onward movement of tomorrow.

The history of nursing education is not coincident with the history of nursing. The latter may be roughly traced through four phases of social experience and while in the first two of these phases no formal attempt at education appears, they had, and perhaps continue to have, their influence upon the medical and popular view of nursing education. The first period is that of home nursing. It consisted merely in the exercise of the natural function of womanhood, and especially of the wife and mother, in the domestic care of the sick. In its exercise there was everything of tenderness and devotion, enlightened by the occasional, desultory instruction of the physician, who assumed to know more and usually knew less of nursing than the household nurse herself. Home nursing was the expression of the intuitive desire of woman to heal the sick, to bind up the broken of body or of spirit, to comfort those who suffer.

The home nursing period has never really ended. It not only overlaps the succeeding phases of history, but it persists through them all and perhaps it always will persist. The home nurse, frequently superseded, of her own volition, by the professional nurse yields her place, as the part of good intelligence dictates, to a more competent helper; but her potentiality of service remains, an inherent right backed by an inherent capacity.

Entrance of the Practical Nurse

Through all recorded time she usually played the part of a good neighbor and whenever she showed particular aptitude for nursing she stood on call in the community. She became, in a word, the parent of that unique composite figure who occupies the center of the second stage of nursing history—the experienced or practical nurse. In the course of time, with the growing complexity of society, an increasing number of women made a business of community nursing. Many of us can think back to the days when no other kind of a nurse was to be had for hire. Sometimes she was efficient and funded to very good results the experience of her passing years. Sometimes her capacity was in inverse ratio to the social need of her services and if her untutored mind happened to run in a narrow mold her society was more of a bane than a pleasure and her nursing was often worse than none. In her group, however, we recall women who were deserving of honor and of more substantial reward than they received. Occasionally, we employed one who proved superior to the early specimens of her presumptively trained successors.

For the third phase in the history of nursing visualizes for us the trained nurse. Florence Nightingale of blessed memory, systematically if chiefly self-trained, has always been regarded as the prototype of this group and that carries its evolution back to 1854. She was certainly the first to apply the science of her day to practical nursing and in doing this she undoubtedly established a new type. She became the administrator and the teacher of almost the first training school for nurses; but the attempt languished and it was reserved for America, almost a generation later, to set the type of school, if not the type of nurse, in this third period. It is a significant fact that the period of the trained nurse is coincident with the rise and development of the modern hospital.

In fact the hospital was the reason of being for the training school. Its economic survival was conditioned upon the pupil nurse. Like the early output of the trade school, she was simply apprenticed to the job, and while the period of her training was called a curriculum, it was nevertheless a period of service and often of very menial service at that. We may readily recall, in our western cities, the essentially domestic quality of the early graduates of the training schools. With all honor to their ambition for personal betterment, crudity was nevertheless their outstanding feature. I remember well my astonishment on my first visit to eastern schools of nursing to note the culture, the education, the refinement, as well as the economic independence of many of their pupil-nurses.

Through forty years of the later development of the training schools I have watched with pleasure the progressive improvement in the quality of their registration; but I have wondered sometimes whether the indifferent attitude of some professional men toward nurses is not a relic of the earlier sense of their inferiority; whether it has not served, in part, to shut the eyes of the physician to the wonderful work of the generally wonderful body of women who make up the nursing profession of today.

*An address delivered before the third annual convention of the Wisconsin Hospital Association at La Crosse, Wis., May 31.

Nurse Reacts Against Repression

I know there are those who even refuse to accord to the calling of a nurse the dignity of a profession. They are simply living in a past when nursing was accounted the function of the domestic. As hospital administrators, these men—for I am sorry to say that they who take this attitude are men—have succeeded sometimes in determining the non-professional status of their pupil nurses, so long as they remained in the hospital school; but a harvest of resentment follows that sort of sowing in the minds of students. The reaction of the repressed woman is toward a professionalism all the more keen and, too often, self-assertive.

For nearly fifty years the institutional or hospital school was the only opportunity of training open to the nurse, the only source of supply of the graduate nurse for private duty or hospital special service. The country is, in fact, deeply indebted to the hospitals for the institution of private nursing in America. The nurse of those early days did not care very much about training. She was content with the school of experience and hard knocks although it was commonly the patient who had to take the punishment. The public had never known anything better than the practical nurse and did not demand that she be trained. But the hospital needed the efficient nurse. It could only get her by training her and rather eagerly and miscellaneously it undertook the task. The training schools multiplied. The organization of a new hospital, whether good, bad or indifferent, carried with it, as a matter of course, a new training school. Too often the nurses' training has been a mere matter of technique. Too often automata in nursing have been turned out, who caught nothing of the inspiration of a profession and were innocent of the spirit of social service. They were deserving rather of commiseration than of blame, for they were the output of a too rigid hospital system and they were too frequently exploited for the benefit of the hospital they served. They might be expected to take their toll of the public since the hospital had taken rather ruthlessly its toll of them.

Nurses Became Dissatisfied

For a dozen years before the War, the symptoms of dissatisfaction with the prevailing system were not wanting among nurses. It was not infrequently said that the extension from a two to a three year training course was in the interest of the hospital service rather than in the interest of the nurse in training. Undoubtedly the lengthening of the course, whether justified or not, was sometimes adopted as a means of slowing up the output of nurses, because with the multiplication of hospital training schools a curious thing had happened. More nurses had come to be needed as undergraduates in hospital service than society needed as graduates on private duty. I made a rather widely extended survey of private nursing in 1908, with the discovery that at that time the nurse in practice was employed on an average of seventy per cent of her time; and by that period society had pretty well developed the expectation in sickness of the services of the trained nurse. And in that day the fee for private nursing was only $15 to $20 a week. There was definitely no shortage of nurses in private practice, and the employment of nurses in public health service was at that time limited to only a very negligible number.

"BARGAIN" OR FIVE-YEAR COURSES

"Short courses for nurses have had the history of a bargain sale. They draw cheap buyers out after cheap goods, and the supply of either soon exhausts itself. The output of these schools belongs to the social order of the ephemera. They are 'little creatures' who have their day and cease to be.

"That high standards of nursing education invite rather than repel students is shown by the fact that the five-year combined courses in arts and nursing offered by fifteen of our major universities in the past year or two are already finding ready takers.

"I believe we are very close to the parting of ways in nursing education. I have no fear that we shall go backward. The tide may temporarily recede, but ebb is always followed by flow. Cheap expedients for increasing nursing registration will not succeed. Students will not accept what they do not want. The problem is one of adjustment. It is a question soon to be met between institutional and university methods of education."—Dr. Beard.

The deficiency of nurses in the hospitals finally became sufficiently marked to lead to the practice of employing graduate nurses in special hospital service, a practice which has grown in the past twenty years. Very naturally the hospitals found the shrinkage of registration an occasion for concern and discussion of the policies of nursing education developed in hospital and medical associations alike. Curiously enough, it hardly seemed necessary to consult the nurses themselves and this lack of cooperation and counsel still measurably continues. In the first instance, their isolation might be traced to a lack of organization.

The profession of nursing, under the leadership of Isabel Hampden Robb, had only begun to organize in the later years of the last century, but it had attained no direct initiative, no solidarity of influence. It was still under the sway of hospital administration. It had hardly begun to act or even to think for itself. It had not acquired a semblance of the strong professional spirit which actuates it today.

Nevertheless, the time was ripe for change in the nursing world. I do not know whether the incidence of events is unconsciously governed by the tides of human thought, but I remember well an experience in June, 1910, which announced not only that a new phase in the history of nursing had been initiated, but that the day of the educated nurse, as opposed relatively speaking to the trained nurse, had come and come to stay. There are those of us hold still to the faith that "What is good—as God lives—is permanent."

In that year, a fortunate bequest had given to the University of Minnesota a teaching hospital and some of us sensed the opportunity to propose the creation of a university school of nursing. We drafted a plan of organization which was adopted by the board of regents. Hardly had this been done when the national organizations of nursing met in Minneapolis. At a joint session, gathering, perhaps, the largest number of nurses ever assembled up to that time, an address was given upon "The University Education of the Nurse" and, without any previous knowledge upon the part of the audience, the action of the University of Minnesota was announced. Instantly,

with an electric wave of enthusiasm, that great congregation of women was on its feet in spontaneous appreciation of a new destiny. The movement has wonderfully developed. In twelve years ten university schools of nursing have been established, while several affiliations with teaching institutions of varying intimacy and more or less doubtful value have been formed.

The First University Training School

The pioneer school at Minnesota, to which the early critics allotted an early death, has maintained the standards with which it started. It is a collegiate school. It enters high school graduates. It gives a preliminary course of scientific instruction. Its growth has been limited by the capacity of its teaching hospital and of the reaction which the limitation has created I shall later have something to say.

Since the year 1910 "much water has passed under the bridge" and many new occasions have taught new duties in nursing education. The great war has been, and the profession of nursing, with everything else in human society, has been disorganized. The response of American nurses to the call of the country in the military and naval services gave witness to the quality of their national devotion, to their capacity for sacrifice, to their sense of professional honor. The draft upon the nursing profession, if temporary, was severe. Some of them did not come back, and those who did came back to find that their own widened sense of opportunity, of a higher destiny in nursing, had been met by the sharply awakened consciousness of the people to the already serious deterioration of the public health, discovered by the statistics of the war. The reaction of the people has been and remains keen. An impetus, never experienced before, has been given to every form of public health activity. The American Red Cross and the National Organization of Public Health Nursing found themselves in the grip of a great emergency and they met the call for competent nurses and for higher education to make them competent, very nobly. The Red Cross peace program pivoted upon the public health and if it be true, as the newspapers report, that the House of Delegates of the American Medical Association has called for a cessation of Red Cross activities in this field, it is greatly to the discredit of the medical profession. It is a matter for regret to many of us who belong to that profession that it has taken so slight an interest, so small a part, in preventive medicine. The claim that politics enters into public health work is a trivial one. It enters into medical organizations as well, and it is only a question of keeping the politics clean. The American Red Cross has not paralyzed; it has been a tremendous stimulus to community interest and responsibility.

Of one thing we may rest definitely sure. The public health program of the people of America is not going to be stopped. The demand for adequately educated nurses in the widening fields of public health activity is going to continue. Women, as nurses, provided they are fitly educated, are the best promoters of public health interests to be found. They find school and home and public forum open to them and already they have given, in visiting nursing, in infant and child welfare work, in public school nursing, in rural community nursing, in industrial nursing, in medical social service, abundant proof of their capacity to serve.

To the superficial observer, not well informed of existing conditions, the temptation comes to let down the educational bars, to propose short courses, to offer a premium to pupils as though they were fish to be caught by bait. One year, two years, we are told are sufficient to give nurses adequate training. It is fondly hoped that if their education is foreshortened they will work for lesser wages, while all experience has proved that the graduate of the two-year school will ask as much for her services as the three-year graduate. It would not take long for the one-year trained nurse to think herself as good as her better trained competitors and to adopt the same wage scale. Professional ethics and individual conscience are matters of education and the less educated the nurse the less likelihood is there of development in her of the spirit of social service. Moreover, we may as well say frankly that the only argument for the rapidly educated nurse is the hospital need and that is not enough to justify a cheapening of nursing education.

Let us take a little account of the facts: Admitted that registration of pupil nurses is lessened, where is the deficiency the more and where is it the less critically felt? It is the small, the inferior, and frequently the short course schools that are the keenest sufferers. The superior group of hospital schools and the schools under university ownership and control are entering increasing and often adequate numbers. The conclusion is very clearly drawn. Women who are seeking a vocation today and particularly women who are entering the profession of nursing are seeking the best education they can get. They are looking not only to private and hospital practice. They expect ultimately to reach out into the higher opportunities of public service. They do not want to be "sub-nurses."

"Bargain Sale" Courses for Nurses

The six weeks' course for nurses of Dr. John Dill Robertson of Chicago has had the history of a bargain sale. It draws cheap buyers out after cheap goods, and the supply of either soon exhausts itself. The output of these schools belongs to the social order of the ephemera. They are "little creatures" who "have their day and cease to be."

That high standards of nursing education invite rather than repel students is shown by the fact that the five-year combined courses in arts and nursing offered by fifteen of our major universities in the past year or two are already finding ready takers. The two years of academic work, the two years in the school of nursing, and the fifth year in advanced study in specialized nursing, public health service, or nursing education are proving attractive. I look to see these five-year courses become the great feeders of the university schools. They lead to the double degrees of Bachelor of Science and Graduate in Nursing.

I believe we are very close to a parting of the ways in nursing education. I have no fear that we shall go backward. The tide may temporarily recede, but ebb is always followed by flow. Cheap expedients for increasing nursing registration will not succeed. Students will not accept what they do not want. The problem is one of adjustment. It is a question soon to be met between institutional and university methods of education.

Two or three things stand out clearly to be reckoned with: The economic need of the hospitals for nursing service must not only be considered, but it must be met. While the hospital is not naturally an institution of learning, it is an instrument of education. It must remain the laboratory in which the nurse receives her practical training. It should confine itself to that function under the standardizing direction and the educational control of the university school.

By association with the university school, as its clinical laboratory, the hospital exercises in behalf of the nurse, precisely as it does in behalf of the medical student, a

limited but a very important educational function. At the same time, it serves to widen the possible limits of registration in the university school, and incidentally the volume of its own nursing service.

In the large cities where major universities or even lesser colleges exist, the association between a university or collegiate school of nursing and the hospital, or group of hospitals, is merely a matter of organization. Distance however is not an insuperable bar to such a relationship.

Hospital Affiliation with Universities

The critical points in such an association are the quality of the clinical service offered by the hospital, the willingness of the institution to place itself educationally under university control; and the standardization of its teaching and the selection of its teaching staff by the university.

Some of my hearers may be inclined perhaps to suggest that the proposal is merely an educationist's dream. Well, it has always been the vision of the educationist, backed by the ideals of the advance guard of the profession, that has made for educational progress. The laws which govern the practice of the service professions have never done it. They only express the average sense of the people by whom they are enacted. They follow always in the footsteps of the schools. The sufficing answer to the critic is that the thing has been done! There is nothing so convincing as accomplishment. Minnesota, which pioneered the university education of the nurse, has established a central university school with which the nursing service of four major hospitals are associated.

Limited until a year ago by the 200 bed capacity of its own teaching hospital, the university had entered in previous years not to exceed thirty-four students a year. Within that period it has accepted overtures to take over the teaching of nursing students from the Charles T. Miller Hospital with 200 beds in the neighboring city of St. Paul; from the Minneapolis General Hospital with 750 beds; and from the Northern Pacific Hospital with 200 beds in the so-called midway district. Its bed capacity for teaching nurses has thus been increased to 1,350 patients.

Within a single year, under experimental conditions and with small publicity, it has increased its registration very satisfactorily. It enters a class in each quarter. Its students take a three months' preliminary course in the related scientific subjects at the university. During this period they are provided with room and board, but they are not entered in hospital service.

In the order of their scholarship, at the close of the preliminary course, they are given choice of either associated hospital as their principal point of residence; but from thence they are assigned to rotation services from time to time in the several associated hospitals.

The association makes a varied and complete course of nursing education an actuality. Students get experience in the nursing of free patients, per diem cases, and private patients. They enter services for the study and care of acute and chronic, accident and emergency cases; contagious diseases, tuberculosis in hospital and sanatorium, and orthopedic surgery. They are assigned to a large obstetrical clinic and to a great dispensary practice in the medical school.

They receive their living and laundry expenses, but they are paid no bonus. They have the same privileges as all other women students on the university campus. They live under student government. They all receive the university's degree.

The problem of the organization of similar central university schools is under consideration in other large cities. The transfer of educational responsibility to the teaching institution, the placing of hospital nursing services under its control, the standardization of courses, the unity of instruction should commend the development of such alliances.

There is every indication that these central university schools will thrive and grow; that they will prove not only an attraction to the beginning student, but to the graduate who is seeking to broaden her vocation. Higher education and particularly professional education is a university function and the chooser of such a calling will set a justly high value upon a university degree.

The history of medical education in America is destined to be the history of nursing education. The private schools have gone or are going out of business. They are merging in the universities or they are becoming extinct. There will be a remnant of small hospitals which cannot associate themselves with teaching institutions and these will eventually abandon the maintenance of schools of nursing and will come to rely more and more upon graduate nurses for service.

No great gain is to be accomplished without some loss. To establish the profession of nursing upon a sound educational basis; to have a university guarantee of the fitness of the nurse for the service of the public; to standardize undergraduate education in nursing; to build upon this broader foundation advanced courses in specialized nursing—these are surely great gains.

No one familiar with the recent history of nursing can fail to realize that there is a social, as well as an educational side to the problems of the nursing profession of today. And with this side the public is equally concerned.

The most serious question is the adjustment of costs for graduate nursing service to the needs of all economically conditioned classes of society.

Nursing Service for the Middle Classes

Nursing costs are not high. They do not exceed the wages of unskilled labor. If graduate nurses worked on hospital or private duty 364 days in the year, they would earn on the average at present rates some $1,800; and everybody knows that they do not and cannot serve in this continuing fashion. A woman who is on hospital service for twelve hours a day or in personal attendance on her private patient for a possible nineteen hours a day cannot keep it up all the while.

Nevertheless, the fact must be recognized and reckoned with that sickness, to the great majority of people, is an economic burden which brings them speedily to the verge of financial disablement, and that to them the services of the educated nurse are as indispensable as to anyone else. The suggestion that they be served by nurses of inferior quality is obnoxious.

The scales of social justice are sometimes curiously unbalanced. The indigent sick are cared for by nurses in more or less advanced training, under close graduate supervision, and they fare well, as they should, at the cost of the people at large. The well-to-do command graduate nursing and often absorb more than their necessary share of the nurse's time.

But, for the benefit of the many who will *not* be indigent and are not wealthy, a careful study of the ways and means by which graduate nursing service may be furnished at graded cost should be undertaken in every state by properly related public bodies in consultation with nursing organizations or with committees of representative nurses.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
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DRY MILK—HISTORICAL AND CLINICAL

By LOUIS J. AUERBACHER, New York City

THE many disadvantages of handling and transporting liquid milk naturally led step by step to condensing. The success of the condensed product encouraged inventors to devise some means by which all the water could be taken out of the milk, leaving only the milk solids. Many attempts were made to make dry milk, and desiccated milk was made as far back as 1868. In 1892 Stevensen and Murphy mentioned dry milk as one of the best forms of concentrated milk. Many inventors have developed different processes, but at the present time there are only two processes that have been developed to large commercial enterprises.

The drying of milk for commercial use is largely done by the spray process and by the hot roller process. When the former method is used, the milk is first pasteurized at a temperature of 140 to 145 degrees F. for thirty minutes, after which it is condensed in vacuum after the manner of the regular condensed milks. The ratio of concentration is about 3½ to 1 for whole milk and about 4¼ to 1 for skim milk. The condensed milk while warm is forced through a small opening in a special designed disc under a pressure of several hundred pounds. This high pressure forces the milk into a large drying room in the form of a fine spray. Within the drying chamber circulating air is heated to about 230 to 240 degrees F. This high temperature causes a rapid evaporation of the water in the milk spray, which evaporation in turn lowers the temperature of the air in the room to about 180 degrees F. As the water is evaporated the milk solids fall to the floor and remain there in the drying chamber for a period varying from four to eighteen hours, depending upon the frequency of removal.

Hot Roller Process of Drying

When milk is dried by the Just or hot roller process the handling and processing by heat are reduced to a minimum. Instead of the milk being heated at any time previous to the actual drying process, it is cooled to 40 or 50 degrees F. in glass lined tanks immediately upon receipt at the factory, and held at this temperature until standardized and run on the drying machines. The actual drying of the milk is accomplished by allowing the cold milk to run between two hollow steel cylinders heated by steam pressure to about 240 degrees F. These steel cylinders are placed close together in such a manner that they revolve in opposite directions. The water in the form of vapor is carried off by suitable draught stacks and the milk solids which remain on the cylinders for only a few seconds as a thin film are cut off by a sharp knife extending the entire length of the cylinder. This film of milk solids, entirely free from moisture as it leaves the knife edge has the appearance of white tissue paper. The film is immediately sifted to a fine flaky powder and placed in hermetically sealed containers within a short interval after the milk has left the cooling tanks.

When taking up the use of dry milk in connection with infant and convalescent feeding, I was much impressed by the simplicity of drying by the hot roller method, and clinical and other tests seemed to indicate that this process had many advantages from a clinical standpoint. I therefore took steps to develop this process and all facts concerning dry milk discussed in this article are the facts as disclosed by the hot roller method of drying.

The drying of milk makes many physical, chemical and biological changes in the milk. It seems to be almost providential that these changes as indicated by clinical and scientific evidence all tend to give the milk a higher nutritive index and make the milk much more assimilable and digestible.

Formula for Infant Feeding

About ten years ago I became interested in dry milk for the feeding of infants and introduced the milk into this country, importing some from France which had been used by a number of doctors with marked success. I took up the matter with a number of infant specialists and others interested and many tests were made so as to evolve the proper formulas, especially the proper percentage of fat which would meet the majority of conditions met with in infant and convalescent feeding. The formula finally arrived at is given below:

Fat	12%
Lactose	46%
Protein	32%
Salts	7%
Moisture	3%

The nutritive value of dry milk having the above formula is 127 calories to the ounce, or if expressed in Prof. Pirquet's unit NEM, it has a value of 6 NEMS per gram.

The references made in this article to the clinical uses of dry milk will be based on the use of milk having the above formula. Clinical evidence of the last ten years all seems to sustain the earlier researches that this formula is the one best borne by the infant as well as the adult. This formula is arrived at by taking off part of the butter fat.

During drying there are changes in solubility brought about in the protein, particularly the casein, when the

milk is dried by the hot roller process. The peculiarities of the drying process change the casein, causing it to rest in a more definite suspension when diluted with water. Many of these particles may be precipitated by centrifuging, a result which cannot be obtained with liquid milk when the same degree of force is used. This degree of insolubility of the casein is no doubt brought about by the heat to which it has been subjected. This condition, however, is of the utmost importance from a nutritional standpoint, as it prevents the casein from forming large tough curds in the stomach. The casein particles are not subject to the coagulative action of the gastric juices, thus offering a much larger area in proportion to their size for the action of the digestive fluids than do the tenacious curds of cows' milk. A statement which is constantly made relative to the milk dried by the hot roller process is that the lactalbumin is entirely coagulated. This statement is not correct; results show that from 50 to 80 per cent of the albumin remains in soluble form as in the liquid milk from which it is made.

Butter More Digestible than Cream

The fat in dry milk is present in a more butter-like condition and in this form is more easily digested than when in the form of cream. It contains more free fatty acids than does cream, and as in the small intestines, where the fats are digested and absorbed, much more fat is taken up in the form of free fatty acids and soaps than in the form of neutral fats, the particular form renders it undoubtedly more easily absorbed than cream. It is of great value that the free fatty acids combine with the comparatively insoluble calcium and magnesium salts present in the intestines to form calcium and magnesium soaps, and thereby facilitate the absorption of these substances which are of great importance for the growth and development, particularly during the early years of childhood.

It is not at all a matter of indifference as to the form, whether as butter or as cream, in which fats are digested, for many a person whose digestion is weak can digest large quantities of butter, but cannot bear cream. This difference in the digestibility of these two forms of the fat may chiefly be due to the fact that in the cream the fat is present in the form of globules of neutral fat which in order to be absorbed must first be split up into fatty acids and glycerin. Butter, on the other hand, contains approximately seven per cent of fatty acids (butyric acid, capronic acid, etc.) and, therefore, is already partially ready for the absorption. Butter, hence, is more rapidly and completely absorbed than cream. When it becomes necessary to add fat to the diet of children and for adults with weak digestion, butter had better be added in most cases, rather than to add larger quantities of cream to the milk, and the more so as experiments by Pawlow have shown that cream decidedly retards the secretion of the gastric juices. Following the ingestion of 600 cc. of milk, 4.2 cc. of gastric juice were secreted in 1 hour, 12.5 cc. in 2 hours, and 13.2 cc. in 3 hours whereas following 600 cc. of cream only 2.4 cc., 3.4 cc. and 3.1 cc. were secreted respectively in like periods. A milk in which the cream has partially become converted into butter is accordingly most advantageous for the digestion, and such a milk we have in the milk-powder milk.

Furthermore, the character of the emulsion exhibited by the milk-powder milk is favorable for digestion, as the fat globules are exceedingly small (their diameter is on an average less than 0.01 millimeter) and they are uniformly distributed through the milk. The uniformity may be even further increased by shaking the milk for a few minutes in a flask, whereby the milk at the same time becomes more palatable on account of its becoming saturated with air.

The tests in artificial digestion have also demonstrated that two constituents of the milk-powder milk, the fat and the albuminoids, have undergone a change which makes them more easily digestible. Even though the processes which take place in natural digestion may vary to a not inconsiderable extent from those that obtain in artificial digestion, the results obtained are nevertheless of great value, particularly for purposes of comparison.

Mineral Constituents Are Compared

In the following table will be found the percentages of the different mineral constituents in fresh whole milk which are in true solution as compared with dry milk in order to show the changes in solubility produced by drying.

DEGREE OF SOLUBILITY OF SOME OF THE MINERAL ELEMENTS IN MILK AND DRY MILK.

	Chlorin	Phosphorus	Calcium	Magnesium	Sodium	Potassium
Fresh cow's milk	100.00	53.60	33.33	53.85	100.00	100.00
Dry milk	100.00	36.62	14.90	15.00	100.00	100.00

In connection with the above figures it is of interest to note the percentages of soluble calcium in the two products. In fresh cows' milk 33.33 per cent of the total calcium is soluble; the dry milk shows a decrease in the percentage of soluble calcium. This change in the solubility is an important factor to be considered in connection with the use of dry milk for infant feeding. Cows' milk when used for infants contains an excessive amount of available calcium which is responsible for the soap stools and protein curds eliminated by most bottle-fed infants. From this standpoint, therefore, any method or process which reduces the soluble and available calcium in cows' milk is a very desirable attainment.

We have briefly outlined some of the changes taking place in the physical and chemical structure of the milk during drying. There are also changes in the bacterial content of the milk and the following table shows the relationship of the bacterial content of liquid milk and the dry film taken direct from the rolls.

Date	Liquid Milk Bacteria per c.c.	Dried Film Bacteria per gram
6/26	2,750,000	270
7/2	12,000,000	550
7/2	147,000,000	600
7/3	280,000,000	880
7/3	345,000,000	520
7/7	1,520,000	520
7/8	2,300,000	520
7/9	3,100,000	200
7/9	1,700,000	1,350
7/11	2,100,000	220

The bacteria in milk powder die off very rapidly during storage, and in normal powder with low bacterial content and normal flora a point of constancy in numbers of only a few per gram is reached after two to four months.

The above results indicate that there is no direct relationship between the bacterial count in the liquid milk and in the powder, providing the machines are being properly operated with constant steam pressure as was the case in these experiments. It is noted that there are marked differences in the bacterial count of the different samples of liquid milk but that the bacterial count of the film remains practically constant. The majority of bacteria found in the film were spore-producing species which can only be killed by exposure to high temperatures for a long period of time. All investigations made thus

far seem to show that no pathogenic organisms survive this method of drying milk.

In addition to the advantages that dried milk seems to have from a nutritional and digestive standpoint, there are of course many evident advantages in the fact that it is a dry powder and can therefore be readily handled and transported and is not subject to rapid deterioration. Four ounces of dry milk represent about a quart of liquid milk. A cubic foot of dry milk represents about 100 quarts of liquid milk. There is therefore great economy in the storing and shipping of dry milk as compared with other forms of milk, and of course it has a distinct advantage in that no refrigeration is required.

The keeping qualities of dry milk are dependent upon a number of factors. First, the liquid milk from which it is made should be of low acidity and be dried as soon after milking as possible. The milk should be packed in hermetically sealed containers so as to prevent the increase of moisture and oxidation of the butter fats. It should also be stored in as cool a place as possible which also tends to prevent acceleration of the rancidity of the butter fats. There are other factors, such as the catalytic action of metals which are also important in connection with the keeping qualities of dry milk.

In recent years the question of vitamins has assumed great importance, and therefore any process which tends to destroy the vitamin content of the food dried should not be employed. There have been many investigations made with dry milk by well known investigators on this important subject, and all researches have conclusively shown that milk dried by the hot roller process has not lost its vitamins to any appreciable or important degree. These researches have disclosed that it is not the degree of heat applied that tends to destroy the vitamin content but oxidation and the length of time heat is employed are the most important factors. It has also been shown that the original liquid milk is high or low in vitamin content according to the rations of the cow, so very often winter milk will be low in vitamins by reason of the fact that the food of the cows is low in vitamins, as compared with pasture fed milk.

Many articles have appeared in the medical press since dry milk was first used for infants in 1903 and much has been written in the various books on infant feeding regarding the use of dry milk. All authorities seem to agree that it has many advantages and its use is now quite general. It is obvious that it has many advantages for clinical and out-patient use. Dry milk can be readily dispensed and will keep in good condition without iceing. The results on a large scale in clinics have shown that the usual high summer infant mortality can be very much reduced as infectious diarrheas are not induced by the use of milk in this form. Dry milk has been a very large factor in war relief work. Its small bulk and high nutritive value has been of distinct advantage in relief work in Europe, and the Red Cross and other organizations have made excellent use of this product.

Dry milk has been found of distinct advantage also in feeding very ill infants and prematures. Many authorities are urging its use as an added feeding for babies getting breast milk. In the majority of cases it has been found that mothers have not a sufficient milk supply but that if one or two feedings per day of dry milk are given, the mother not only has an opportunity for recreation and rest but her milk supply is much improved. It has often been found that breast feedings could be maintained by the addition of such dry milk feedings whereas otherwise they might have had to be discontinued. Dry milk is well borne by infants as an added feeding and is also very economical, as a can will last a long time and the contents do not deteriorate after being opened.

The success of the use of dry milk with the very sick baby has naturally led to its use for those suffering from impaired digestion and for feeding in febrile conditions. In tuberculosis, empyema, typhoid, and in fact all invalid feeding cases, dry milk has proved of distinct advantage.

Instead of being given in a liquid form having approximately the same milk solids as contained in liquid milk, it can be given with very little water added, and thus a maximum amount of highly nutritious food, small in bulk, can be given.

To sum up: We might say that dry milk is a form of milk possessing every advantage from all standpoints over other forms of milk, and therefore would lend itself to all types of feeding cases. Given the same skill and care in use as that given to other forms of milk, the results should be better owing to the fact of its high nutritive and digestive value.

NEWS ITEMS

Miss Bertha Wood has given up her work at the Food Clinic, Boston Dispensary, to take charge of the food and nutrition work in the Seminary at Northfield, Mass.

Miss Marion Peterson, formerly of Swedish Hospital, Minneapolis, is administration dietitian at Lakeside Hospital, Cleveland. She will have charge of all administrative work.

Miss Jean Ferguson gave up her work at Butterworth Hospital, Grand Rapids, Mich., recently to accept a position at Hackley Hospital, Muskegon, Mich. Miss Zoe Fink follows her at Butterworth.

Bulletins issued by the Chicago Dietetic Association contain the following announcements:

"Miss Ruth Chambers, who was formerly at Michael Reese Hospital, is now at St. Luke's. Her successor, Miss Alma Kitte, comes from the Vanderbilt University Hospital, Nashville, Tenn."

"Miss Ila Monohon and Miss Lillian Carr, pupil dietitians at Cook County, and Miss Sylvia Andurski of Michael Reese are now on the Infant Welfare Society staff."

Miss Anne Upham, who has been with the U. S. Rubber Co. since leaving the service, was married June 6 to Dr. Everett Whitcomb. They are living in New York City.

Miss Adeline Wood is assistant dietitian at Mount Sinai Hospital, New York, in charge of the kitchen in the new private pavilion. Miss Wood is well known in the world of dietitians through her association with hospitals in various sections of the country—St. Luke's, Chicago; University Hospital, Omaha; and Walter Reed, Washington. Miss Minna Roese is assistant dietitian in charge of the diet kitchen, taking the position previously held by Miss Helen Glasier. Miss Roese was formerly with Miss Bertha Wood in Boston.

Miss Troutt, who has been assistant dietitian at Massachusetts General Hospital, has accepted a position at the Indiana University Hospital, Indianapolis.

The regular meeting of the Chicago Dietetic Association was held on Friday, April 21 at the Hospital Library and Service Bureau. Miss Mable Little, who was formerly in charge of the tea room at Marshall Field & Company and who is now director of halls and commons at the University of Wisconsin, gave a very delightful talk on "Tea Room Management." The problems and possibilities of this line of work were presented in a very practical way.

A SUITABLE DIETARY FOR THE WARD PATIENT

By ESTHER H. FUNNELL, Instructor in Nutrition, Department of Dietetics, Lakeside Hospital, Cleveland

HOSPITAL administrators are continually having to face the problem of food service and its accompanying complications. To a certain extent the solution of this problem must rest with the individual hospital, yet the principles which underlie a well organized system of food service are so general as to afford profitable discussion.

The reputation of a hospital, particularly among the laity, is affected to no small degree by the kind of food served, the variety of the menus and the service itself. There will be "kickers," of course, but no hospital wishes to have a majority of dissatisfied patients and a staff of complaining workers. An analysis at this point may throw some light on the causes of dissatisfaction.

"Unfamiliar food and hospital surroundings have a definite psychological effect upon the physical condition of the patient," says Miss Esther H. Funnel in the accompanying article. "These factors also account to some extent for untouched trays and the consequent food waste. It is essential for the dietitian to remember that it is not the printed menu which is indicative of the food service, but the actual food as presented to the patient. The tray must be attractive; the hot things must be served hot and the cold things cold. All food must be well prepared. Moreover, if any correlation between the diet and the condition of the patient is to be recognized, it is not sufficient to know what food is sent in on the tray. The actual food intake of the patient is the only factor which will offer knowledge of any scientific value to the dietitian."

First of all, who are the patients? The private cases constitute the smallest part of the problem. They are paying for their stay in the hospital and in most cases are paying amply to admit of a variety of the best foods and adequate methods of service. These patients are for the most part average American people who are more or less familiar with the sort of meals the hospital will offer. There are, on the other hand, the ward patients who furnish little or nothing toward their maintenance. Among this group will be found the poorer class of Americans as well as the foreign-born. There will also be a small number representing a better class of people whose financial circumstances will not stand the expense of a private room. The result is that old and young, black and white, those with moderate means as well as the very poorest will find themselves snatched from home life of every description and grouped together amid the most unnatural surroundings.

Patient Often Faces Strange Menu

Perhaps, you say, they are too sick to know or care, and yet there must inevitably be a marked psychological reaction. Is it any wonder? Take, for example, an Italian laborer whose noonday meal might consist of a part of a loaf of bread hollowed out and stuffed with cooked eggs and raw onions and who would come home at night to a one-dish meal consisting of meat and greens cooked with oil and highly seasoned with garlic, onions and pepper. There have not been enough chairs in his kitchen nor enough plates or forks to permit the whole family to eat at the same time. One day he suddenly becomes an accident case in a hospital ward. His first tray will present untold difficulties. Instead of his one dish meal there appear four or five dishes, and he is apt to begin on the one which seems to look most familiar. There will be soup such as he never "drank" before, and three spoons from which to choose. There may be mashed potatoes and perhaps chocolate pudding which are completely foreign to his taste. In his complete bewilderment and fear of the unknown he will probably not do justice to a perfectly good meal.

This illustration is not meant to suggest a foreign-born cook for each group of patients with orders a la carte. Its purpose is merely to show the psychological effect of unfamiliar food and hospital surroundings upon the physical condition of the patient. It may also account to some extent for untouched trays and therefore actual food waste. It is essential to remember that it is not the printed menu which is indicative of the food service, but the actual food as presented to the patient. The tray must be attractive, the hot things must be hot and the cold things cold. All food must be well prepared. Moreover, if any correlation between the diet and the condition of the patient is to be recognized, it is not sufficient to know what food is sent in on the tray. The actual food intake of the patient is the only factor which will offer knowledge of any value.

Educating Patient and Community

In planning the meals for the ward patients, the dietitian must keep in mind the patients as individuals. The food must be simple and inexpensive, and, above all, well cooked. This presents a great opportunity for teaching the patients how to achieve a variety. The actual serving of this variety must be followed by frequent explanatory talks and by giving out printed recipes to the patients. It is absolutely essential to depart from the custom of serving chops, fowl, and other expensive foods in special diets if we are to be of service to the patients themselves.

There are also other groups of people in the hospital who can receive instruction under the direction of the dietitian. Among the employes there will be a large number of maids, each one probably representing a home in the community. They will naturally absorb a few ideas from the food which they see being prepared or served. A system of class work instruction, on hospital time, should aim to correlate these ideas in the minds of the workers. They should learn proper methods of preparing food and how to plan a variety on a small income. At the same time the instructor may teach them the care of cooking utensils and something about general habits of cleanliness. A certain amount of this knowledge will be reflected in the homes of the employes and the hospital will have done a small bit towards raising the standards of living in the community. On the other hand, there will be more intelligent service in the hospital and a better grade of work done.

Perhaps the points which have been outlined may offer some suggestions to hospital administrators of the opportunities which lie within the range of the dietary department.

Hospital Equipment and Operation

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by Frank E. Chapman, Director
Mt. Sinai Hospital, Cleveland, Ohio

RESEARCH AND ITS APPLICATION TO THE POWER LAUNDRY

By ALICE L. WAKEFIELD, Industrial Fellow, Laundryowners National Association Fellowship, The Mellon Institute of Industrial Research, University of Pittsburgh, Pittsburgh, Pa.

More things than mere soap and water enter into successful laundering in the hospital. Standard procedures for the washroom have been worked out, but the hospital superintendent and laundry director need a knowledge that extends beyond washing supplies and methods. Certain definite factors enter into the washability of a fabric; among them are the mechanics of weaving, the chemistry of finishing, and the usage to which the fabric is subjected. If table linen shrinks near the selvedge that is the result of poor weaving mechanics. Bleaching, dyeing and sizing, all have a direct bearing on successful laundering. Careless usage of linens necessitates extreme treatment in the laundry with a consequent lessening in service. Miss Wakefield's article will give hospital laundry managers a glimpse into the vistas ahead in scientific laundering.

THE commercialization of that time-honored institution, the wash tub, has been fraught with much of romance and adventure. It was no easy transition from handling one family washing a week to handling several hundred family washings a day. Not only were there many times the quantity of actual laundering labor necessary, but new tasks were encountered. The collection and delivery of bundles have come to occupy the full time of a small army of workers; another group is kept busy eight hours daily at what was once a Sunday night practice for mother—"sorting the clothes." There must be washers, ironers and wrappers, and a complete office force to keep account of the activities of the whole group.

Fortunately for the laundryowner, there were some advantages to be gained by doing many bundles under one roof. In the first place, it enabled him to afford special machinery that could wash and iron more satisfactorily, in regard to both speed and finish, than was possible with the home types of machines. But after years of work in which various problems in mechanical technology had been met and solved, it was discovered that the game had just begun. The public was becoming accustomed to the service of the power laundry as a necessity rather than as a luxury, and as a result the standard for service was rising. The color of the work was no longer considered good; buttons were being torn off; fabrics were being damaged by careless application of washroom reagents: these were a few of the complaints entered against the power laundry. The laundryowner did not stop to ask how just such complaints were or how prevalent such conditions were in the home before the work had been entrusted to his care; but, with the zeal of a true enthusiast, he set about perfecting the chemical and physical technology of laundering as applied in commercial plants.

When he came to analyze the situation, he found that, to launder a garment, one needs water and soap and blue and numerous other materials that were known only under trade names. Sometimes the product was good and sometimes it was poor, in spite of all efforts to insure against changes in the procedures employed. Further analysis of the situation by the laundryowner himself was impossible, because to him soap was only soap, and water was merely water. Why soap was soap and how it acted, why water was water and what complications might result from the use of impure water, were as great mysteries to him as to any other layman. And here the industry stood for some time, each man doing his best to obtain the key to the situation.

For the past eleven years it has been the privilege of Pittsburgh, Pa. to have one of the most unique and stimulating aids to industrial progress to be found in the world. The Mellon Institute of Industrial Research of the University of Pittsburgh, where the chemical problems of many industries have been successfully solved, attracted the attention of a group of local laundryowners, who established in 1914 an industrial fellowship for the investigation of laundry problems. These pioneers were permitted to monopolize this service for only eighteen months, when the Laundryowners National Association assumed the financial obligations of the fellowship and opened its services, free of charge, to the national membership of nearly 2,000 individual laundries. The fellowship is still in operation, and each month it enlarges its field of service and establishes it more firmly as a vital adjunct to the proper functioning of the modern power laundry. Its personnel has increased from one investigator to three; its duties have grown from the investigation and control of laundry processes to include educational work with the public as well as the laundries, and coöperation with such allied industries as the manufactures of laundry supplies, dyes, and fabrics. (See Fig. 1.)

The first problems attacked by this Industrial Fellow-

Figure 1.—A view of one of the laboratories of the Industrial Fellowship of the Laundryowners National Association at the Mellon Institute, University of Pittsburgh.

ship were the standardization of washroom supplies and washroom methods. No member of the Laundryowners National Association now need be uncertain of the nature of the materials which he wishes to use. A sample submitted to the association laboratory in the Mellon Institute furnishes the desired information as well as advice respecting the value of the product as compared with standard materials. For it was first necessary to establish definite standards for supplies and procedures before individual problems could be answered. This work of standardization has been assembled and presented to the membership of the association in the form of a book, the *Manual of Standard Practice for the Power Laundry Washroom.* Standard formulas for washing all types of fabrics have been presented, together with discussions of water, soap, soda and other supplies which are used in the laundry. These discussions are designed to enable the individual laundryowner to control local conditions so that the standard formulas are applicable.

The possibility of the public laundry acting as a disseminator of disease has not been overlooked. The bacteriological findings of the laundry fellowship have been upheld by work done by the United States Bureau of Entomology[1] and by the United States Public Health Service.[2] The conclusions may be summarized by saying that the average laundry process, including a treatment for at least twenty minutes at a temperature between 140°F. and 160°F., destroys all pathogenic non-spore bearing organisms. The dry rooms and tumblers and the ironing process are sufficient to finish the sterilization of all garments. These conclusions were considered when the standard recommendations were prepared for the association by the industrial fellowship.

During the period of investigation which preceded the announcement of a standard procedure for the washroom, it was discovered that the procedure could be standard only as the materials to be laundered were standard. Consequently, the study of textiles were undertaken with the view of determining their components and the influences exerted on each by the several stages of laundry technology. It is common knowledge that our clothing is made of four main types of fibers, viz., cotton, linen, wool and silk; but how many of us know why these few fibers have survived the test of time? What characteristics do these materials possess that enable us to form them into fabrics which will meet our demands? And again, what demands do we make of fabrics?

Fibers That Survive in Fabrics

In the first place, a fiber, in order to comply with the needs of our modern methods of textile formation, must process sufficient length to permit it to be spun or twisted with its fellows into a continuous thread suited to the process of weaving. If it were only necessary that the fiber be possessed of such qualities as to permit it to be woven into a fabric by our present methods, the list of available fibers would be much longer. But this is not the case. The demands made upon textiles by the consumer are that they be soft, pliable, strong, beautiful and capable of being renovated; and, in special cases, that they be able to absorb moisture readily and insulate the body from heat and cold. These characteristics may be woven into a fabric only when they are possessed by the individual fibers that form the threads. It may readily be seen, therefore, why no more than four of all the fibers produced by nature possess all the features which make them desirable for clothing materials.

The natural features of the fibers may be sacrificed or intensified by the mode of weaving employed. A strong fiber, poorly spun and loosely woven, may furnish a far weaker fabric than an inferior grade of fiber, well spun and closely woven. It is always necessary to sacrifice some degree of strength and utility to obtain beauty by means of patterns woven into the fabric. The high development of the art of spinning and weaving makes it difficult to detect the true composition of a fabric. Cotton is made up to resemble all-wool flannel; artificial silk is presented as true silk; rugs and towels have been found composed mainly of paper. Therefore in the development of the washroom formulas it has been necessary to study both chemical and physical effects on the fabrics. It has been found that cotton and linen are related both in origin and chemical activity, while wool and silk may be classed together for similar reasons.

Cotton and linen, the vegetable fibers, are the least ac-

Figure 2.—The shrinkage is confined in this table linen to a group of warp threads near the selvedge. Such localized damage cannot be regarded as the result of improper laundering even when one is ignorant of the real cause. The real cause is that the affected threads have been held under greater tension on the warp beam than the other warp threads have. This tension was continued during the finishing process until the sizing had dried and a straight fabric was insured. Laundering has merely removed this tension and has permitted the threads to assume their normal positions.

1. U. S. Public Health Report 36, No. 14.: "The Adaptability of Modern Laundry Machinery to Various Requirements for Delousing and Disinfection."
2. U. S. Public Health Reports, Vol. 32, February 9, 1917, p. 243.

tive chemically. They will stand treatment at higher temperatures and with greater concentrations or reagents than the animal fibers (wool and silk). Then, too, they can survive greater mechanical action without serious detriment to the fabric. Since cotton and linen garments usually receive harder wear, and, as a consequence are soiled more than silks and woolens, it is well that they are able to stand the more severe treatment necessary for proper renovation.

Besides the chemical and physical properties of the fibers themselves, there are certain other factors that influence the washability of a fabric. These are the mechanics of weaving, the chemistry of finishing, and the usage to which the fabric is subjected. A good example of the difficulties encountered as the result of poor weaving mechanics appears quite frequently in table linens. The fabric will shrink in a stripe near the selvedge. The unshrunken portion an each side is puckered and can not be ironed smooth. (See Fig. 2). The shrinkage always occurs in the warp threads and may be accounted for by the fact that the threads affected have been strung on the loom under greater tension than the other threads. This tension is maintained throughout the weaving and finishing processes, and the fabric is purchased in apparently good condition. However, yarns assume a normal tension in the presence of moisture (which change is termed shrinkage) and it is to be expected that the shrinkage will be greater in threads that have been worked up under the greater tension.

An Example of Unethical Stretching

While shrinkage is under discussion, the reader may be interested to learn that the yardage of a manufacturer's output may be increased greatly by the simple expedient of stretching the cloth during the finishing process. When preparing to weave a fabric, calculations are made on the number of threads that are to occur to the inch. The theoretical number of threads necessary to produce a fabric thirty inches wide will in practice weave up to less than that width. Unless this fact is taken into consideration, the fabric must be stretched to measure thirty inches and must be dried under tension so that it will remain in that condition. A case has been observed in the Mellon Institute of a tissue gingham that shrunk from twenty-seven to twenty-five inches in width and lost only three inches in a six-yard length, when merely wet with water and pressed. The shrinkage in length was legitimate, because, to obtain an even, firm fabric, some tension must be exerted on the warp in the loom; but the shrinkage in width was the result of unethical practice on the part of the manufacturer.

The chemistry of finishing involves the bleaching and dyeing of fabrics, as well as the application of sizing materials. Occasionally one may find a piece of cloth that has been tendered by the action of the material used to size it, but the greatest difficulty lies with the bleaching and dyeing processes. During the period of bleaching chemical reagents are used which may cause irreparable damage if unfavorable conditions are permitted to occur. By careful supervision all damage may be avoided; but if certain precautions are overlooked during the progress of the treatment, the fabric may be ruined. The manufacturer is not always aware of the disaster and a piece of cloth may be released which will not give the service that is to be expected from it.

The dyeman in his turn may have many difficulties. One of the most exasperating conditions with which he must deal is the effect of sulphur dyes on vegetable

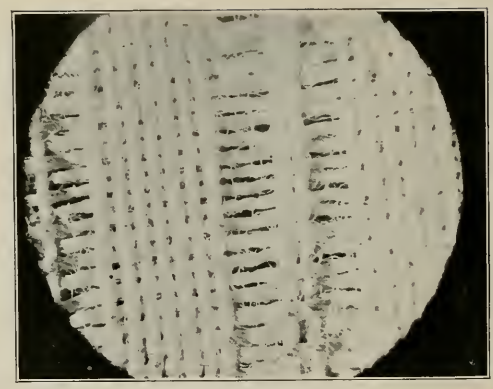


Figure 3.—A madras shirting after the black threads, forming the stripes, were removed. The threads were so tendered by the sulphuric acid formed from the dye, that they readily dissolved in soap and water during the laundry process.

fibers. Sulphur black is especially trying. The sulphur dyes are used widely because they are very satisfactory in regard to color, ease of application and cost. Unfortunately, however, some of their sulphur content (from which they derive their class name) will oxidize to give sulphuric acid, an acid which is extremely corrosive to vegetable fibers. It is so corrosive, in fact, that threads dyed with sulphur black and used to form stripes in madras shirtings are often affected to the extent that they wear or are washed from the fabric with ease. (See Fig. 3.) So far it has been denied the chemist to discover just what conditions favor this change to sulphuric acid.

In the home and in institutions, linens are frequently used in ways for which they are not intended. But suppose that we consider only what might occur in the pursuit of one's normal routine. The business man whose car is his hobby takes little consideration of the storage batteries. A little splash of liquid from them is entirely without significance to him, yet this liquid contains sulphuric acid, which is corrosive to cotton and linen. The housewife knows nothing of the nature of hundreds of articles used daily in her routine of homemaking. Many of them are strongly corrosive chemicals that are handled with great care by those who know their nature. Few physicians and nurses realize the destructive nature of some of the medicines they handle every day. In the recent epidemic of influenza, that well known tonic combination, "I. Q. S.," was consumed by the gallons. The iron is present as soluable ferric chloride, which readily attacks cotton fibers. The Dakin-Carrell solution is the laundryman's old friend javelle water. The laundryman knows that it must be handled with care but all users do not.

A treatise prepared by the Laundryowners National Association fellowship deals with the important subject "The Conservation of Textiles" and includes a plea for a pure fabric law to be similar in scope and value to the present pure food law.

Research and its application to the power laundry! We have discovered that its application is wide. So wide, indeed, that it could well have a subdivision—research in its application to the ultimate consumer. The ultimate consumer does not realize the fascination of research; were such the case, this branch would already be established.

HIGH PRESSURE STEAM: A HOSPITAL NECESSITY

By FRED WOOD PHIFER, M.D., Medical Director, The Wheatland Hospital, Wheatland, Wyoming

IN THE last few years there has been built a constantly increasing number of small hospitals ranging in size from five to 100 beds. It is probable that there are now ten of these for every one of a larger size, and that they care for a total number of patients not far below the total cared for by the combined large hospitals of the country. The problems of these smaller hospitals are therefore of increasing interest; but they are so comparatively new that there are not many persons of sufficient experience to speak with authority concerning them. And yet, of course, conclusions without experience have no weight.

It is for this reason that, before giving expression to any opinions on steam, I ask permission to write in a rather personal way of my own experience acquired in the building and management of a hospital that has grown from two to 100 beds, covering in twelve years most of the stages in between.

Some years ago I found myself in a little western town with a sick wife, a head full of surgical knowledge and an empty pocketbook. In a very short time I found the climate beneficial to my wife and in a few more months decided that my surgical knowledge would be a real asset if I could put it to some use. The sick, the maimed and the crippled we have with us always, even in healthful Wyoming.

Up to this time I was living in a hotel and depending upon my practice to yield enough to pay expenses each month. I finally located an office and a house. And then my troubles began, for I commenced to get the full force of the fact that I was in a small western town without water works, sewerage or electricity.

Installs His Own Plumbing System

This would be a long story if it told all the details. There was no plumber in town and I couldn't afford to import one so I dug my own ditches, fitted my own pipes and finally got in the first plumbing known to the town, learning many a valuable lesson while doing it. And in time all of the apparently insurmountable difficulties were overcome, and the hospital has grown and prospered.

But, if I leave out details of growth along other lines, I do want to describe the various stages of evolution in our methods of obtaining heat and power. Our first heating apparatus was a big base-burner, and our first sterilizer a little low pressure affair on the kitchen stove. Gloves were boiled immediately before using and put on wet. The kitchen stove method was better than none, but presently we reached the gasoline outfit in a sterilizing room set apart for the purpose.

Then one night, after playing with my small boy's steam boiler and engine which Santa Claus brought him from the toy shop, I decided to put a small vertical ten-horse power boiler in the basement and pipe steam to my low pressure sterilizer, putting a ⅜ inch galvanized pipe in the bottom of the sterilizer to act as a steam coil. I soon had it all going, and oh, what a satisfaction to get away from the gasoline method of heating with its thousand and one objections.

The next step was to add a five-horse power steam engine and a laundry tub. You see we have jumped from the original dwelling (with its two rooms for patients, operating room and a room for nurses) to a small newly built hospital, supposed to accommodate ten patients but quickly crowded with fifteen. This new hospital building was first heated with a hot water plant, but the next year when another and larger wing was added this plant proved inadequate, so that a low pressure steam heating system was substituted. As the hospital grew, more and more sections had to be put in.

Decides on High Pressure Boilers

In 1918 we were again building extensively, and a new and larger boiler room was planned. One day while watching the work, I suddenly told the engineer that I had a vision, and ordered the excavation for the low pressure heating plant discontinued. I was going to put in two high pressure boilers. Here I met with all sorts of objections from architect, engineer and plumber, not to speak of everybody else that felt entitled to an opinion on the subject; but I was obstinate and stuck to my decision. I had a competent man select two high pressure horizontal steam boilers, fifty and one hundred horse power, respectively. Under protest, I put them in, installing a reducing valve for heating purposes. And I have never regretted anything about the decision except that I did not order both boilers to be 100 horse power, as we have found it to be economy to fire the larger boiler. The new plant is less trouble to fire than the old low pressure boiler, and gives us all the steam we want, whether high or low, for heating or for operating purposes.

As you will have gathered from our history, we have tried practically every method of heating, and we are convinced that for any hospital that intends to do serious work, regardless of size, a high pressure steam plant is the thing. It should be sufficiently large to generate both heat and steam for general use.

It is probable that many will disagree with this conclusion. Certainly many architects for smaller hospitals are not of this opinion. Not far from us is a well planned and beautifully appointed hospital of 100 bed capacity. I had the pleasure of being shown over this hospital soon after it was opened, and it was a real pleasure too, for it was wonderfully planned, wonderfully built and wonderfully equipped. But when we reached the engineering department, I was astonished beyond measure to find a low pressure heating plant; and beside it, to generate steam for sterilizers and for the laundry, a high pressure vertical boiler that touched the ceiling. I asked the superintendent how they were going to clean the flues, and she naively asked: "Do you have to do that?"

A year later I visited them again and found she had learned a lesson, for there was a big hole in the ceiling over the vertical boiler, so that the flues could be drawn up into the room above, which had to be abandoned to the purpose. Moreover, in the backyard a new building was going up in which was being placed a new power plant and the laundry department. High pressure horizontal boilers were going in, and the old low pressure heater was for sale. Like ourselves, this hospital had learned by experience, but both of us would have saved much money and grief, if we could have had the benefit of some one else's experience.

We will grant without argument that for a high pressure plant closer attention is necessary than for a low pressure heater, and this requires more men in the engineering department. But my settled opinion is that a hospital can no more afford to do without steam all of the time than it can afford to do without nurses or a competent surgeon.

Heating Plant in Main Building Cheaper

Before we discuss the uses and convenience of steam, we might consider the location of the plant. From many points of view, it is better to put the heating, power and lighting plants in a separate building. Nevertheless, in a small hospital it is economical to have the heating plant in the main building; saves at least one-third in heat that is unavoidably radiated in the boiler room and laundry. The large two-story wing over our heating plant is not supplied with steam at all, as I had a special valve put in the steam line so that this entire wing may be kept cut off, and yet it is so much warmer than the rest of the building that we set it aside as winter-quarters for the "old crips" who require extra heat.

It is our conclusion that a separate power plant is desirable, but it is not a necessity; and, where economy is a prime consideration, it seems better to me to sacrifice the cost of the extra building rather than something else more essential.

Whether the plant is on the outside or in the main building, it should be so placed that the prevailing winds will carry the heat towards the building and not away from it. It is surprising the difference this makes, as is clearly demonstrated when the wind is from other than the prevailing direction. Be sure that the architect plans not only a convenient entrance for coal but a convenient exit for ashes. For two 100 horse power boilers which are to be used alternately, there should be storage place for at least two car loads of coal. If coal is used for kitchen ranges and the like, a smaller separate storage room should be provided as a different kind of coal is required.

The steam engine, light plant and other machinery should be next the boiler room, but in entirely separate quarters.

Our high pressure steam plant furnishes heat to the building; power for running the steam engine, the light plant and the laundry plant, and an automatic air pump that furnishes air for our auto tires in the garage and acts as a force pump for the 4,000 gallon emergency water tank; it heats an abundance of hot water for use all over the house; furnishes steam to the kitchen for cookers, steam tables and dish washers; steam for the diet kitchen, for the two sterilizing plants connected with the operating rooms, for the nurses' work rooms and for bedpan sterilizers in each utility room.

Safety Device Controls Pressure

For heating, my favorite method is steam, and as I have said, I have tried all kinds, from the kitchen stove up. At the present time, we have two high pressure steam boilers set up side by side and piped together so that the steam from each or both boilers is readily obtainable at will. For heating purposes this steam, of course, must be reduced. A safety apparatus for this purpose is installed, which allows steam to pass at from one to four pounds, according to the way it is set. An additional safety gauge is also installed further out on the line. In this way, if anything should happen to the reducing diaphragm and high pressure steam should get by, this second valve would pop off at four pounds, making it impossible for high pressure steam to reach the radiators.

On the side of the large common pipe line near the boiler, a two inch pipe line is connected which gives us our high pressure steam for running machinery, sterilizers and cookers. As mentioned elsewhere, the exhaust steam from the engine is also utilized. All valves and checks are carefully tagged so that any one who can read can easily understand which valves to open and shut. I am no steam engineer, but I have received a great deal of pleasure from studying out the practical uses and the complete utilization of steam in our building.

We carry from 40 to 80 pounds of steam the year round, except for the summer nights. During the warm months after six p. m., the fire is banked so that by 5 a. m. only 10 to 20 pounds of steam is registered. This amount of steam is sufficient for the sterilizers in the utility rooms; and if more is needed in an emergency it can be quickly raised. The day fireman comes on at 5 a. m. In the winter an extra fireman is on duty, and fires are banked at 12 midnight and opened up again at 4 a. m.

There are valves in the main steam lines so that any desired wing of the building can easily be put out of service; and, of course, any single radiator may be turned off at will. It is but the trick of a moment to turn on again the heat and it can be done without any noise or annoyance. A little watchfulness prevents much waste.

The steam, when condensed into water, is returned to the boiler by an automatic pump. More modern traps may now be used for this return flow to the boiler.

Plenty of Hot Water at Low Cost

Hot water for the house is furnished by two tanks, one 500 gallon for general use and one 200 gallon for the kitchen supply. The water is heated by live steam which is run through a two-inch pipe inside a six-inch pipe, that carries the water to the tanks. The condensation from the two-inch steam pipe is emptied into the main return from the radiators to the automatic pump and then to the boiler. In the summer when our laundry engine is running, the exhaust steam from this engine is thrown into this water heating pipe, and the direct steam line is cut off. In the winter months this exhaust steam from the engine is thrown into the main steam lines to heat the building, after first going through a separator which extracts all the oil and grease. The automatic pump is also run by steam, and the exhaust from this is used in the same way for heating water. By using this exhaust steam, we have an abundance of very hot water at a low cost.

The laundry machinery is run by steam and not electricity since the supply of the latter is uncertain in Wheatland, as it is in most small towns, and the cost is prohibitive. Our washing machines are brass and were especially built with a view to being steam tight. After the stain-removing process, the live steam is turned in, and every piece is sterilized except woolen goods or articles that are not color-fast.

Many smaller hospitals do not operate their own laundries, but we believe that a laundry is essential. There are a number of arguments in its favor, but none more important than this feature of sterilization. The first cost of the steam-tight tub is considerable, but the tub is durable; and it certainly is a satisfaction to feel that your patients are safe from any danger of cross infec-

tion through the linen. Its own laundry allows the hospital to use linen freely. This is hard on the linen, but it is mighty good for the hospital. Another advantage of having a laundry is that washing is done every day, and not so much linen has to be in stock at one time. This makes it much easier to keep up with the supplies.

Finally I believe the operation of a laundry pays the hospital in dollars and cents. In many cases the laundry can be made partly to pay its way by doing flat work for outside parties, such as hotels and boarding houses. Our laundry does this; and I know of several other hospital laundries which do the same thing with entire satisfaction to all parties concerned.

A large steam line goes direct to the kitchen, where the steam is used for cookers, steam table, dish warmers, dish washers and a sterilizer for milk bottles and milk cans. Not all of this equipment is necessary in every small hospital; but as the Wheatland Hospital owns its own dairy and produce ranch, it was essential to provide a sterilizer to care for the milk utensils.

Generate Own Electricity by Steam

The steam engine that runs the laundry machinery also runs our generators and supplies us with light. In addition we have an oil engine to run the generator at such times as the steam engine is not in use. We were forced to put in a light plant because until recently the town did not furnish the twenty-four hour current; but we feel that no hospital can afford to be without an individual plant that will be sufficient for emergency purposes. The operating rooms and maternity delivery room, at least, must be provided with a never-failing light system. In this hospital, in addition to light, our own plant supplies the current for our call system, dictaphones, telephone switchboard, and a rather extensive equipment by way of appliances for electrical treatments. In short our own plant serves every purpose except supplying current for the x-ray department. The x-ray equipment is not connected at all with the general wiring of the building but is supplied direct from the city plant on its own individual line.

The high pressure air pump, which is mentioned in a previous paragraph, is run off the same shaft as the generator. This pump is connected with a large air tank in our hospital garage, which is under the same roof as all the rest of the building. This pump, in addition to furnishing air for automobile tires, furnishes pressure for our large reserve supply water tank. This insures us against the possibility of ever being without water. We have had occasion more than once to be thankful for it.

And now we have arrived at the principal necessity for a constant supply of high pressure steam in a hospital, sterilization. In the operating rooms, it scarcely needs discussion. We have two entirely separate sterilizing plants, as our operating room for dirty cases is not even in the same wing as the main operating suite. For this secondary operating room, we have the usual large automotive and a utensil sterilizer, but the instrument sterilizer is electric as it is in frequent use both day and night. This electric sterilizer is satisfactory, but now that we have twenty-four hour steam service, there is no reason why it should not be a steam sterilizer, which we prefer because it heats the water more quickly.

The other sterilizing plant is situated between the main operating room and the maternity delivery room. In addition to the autoclave, instrument sterilizer and utensil sterilizer, there are three sterilizers for water, providing hot, cold and distilled sterile water at all times.

A Practical Utensil Sterilizer

But when you have proper sterilization in the operating room, you have just begun. And right here, I want to describe a homely apparatus in the main utility room, because, though simple and inexpensive, it is extremely practical. It consists of an ordinary clothes boiler in the bottom of which is a small steam coil connected directly with the main steam line. A faucet is attached to the side of the boiler to draw off the water or to drain the boiler. By simply opening a steam valve you have a quantity of boiling water in a few minutes, much more quickly than by electricity or over a fire. This simple apparatus is a perfect utensil sterilizer for a wide variety of articles in daily use from baby bottles to rubber tubing. A removable pan adds to its usefulness. It heats the babies' milk more quickly than the electrical hot plate with no danger of the milk boiling over if the nurse leaves it for a moment. It can even bake a custard, if desired. We find it simply indispensable, and yet it may be had at the outlay of a few dollars for material and an hour or two of the mechanic's time.

On each floor in each wing we have a bedpan sterilizer installed in the utility rooms. What a satisfaction to know that your bedpans are as clean as your breakfast dishes! We tried several makes of bedpan sterilizers before we found one that was satisfactory; and even in this one we asked for a few changes in order to make it, as we think, ideal and practically foolproof. The contents of each bedpan is sterilized every time, and at the same time the bedpan is washed and sterilized. The nurse need not even soil her hands, although we require that she shall wash them carefully before removing the pan from the sterilizer, which is opened and closed with a foot pedal.

We believe that many infections travel by the bedpan route, even when their use is not indiscriminate. We do not have public wards at all; and we tried having a bedpan for each room and for each patient, but the most careful regulation did not make even this satisfactory. But our bedpan sterilizer methods are working out satisfactorily. Individual urinals are used for each patient and all are boiled once a day. In the utility room of the isolation wing there is a hopper with an open steam line for sterilizing the linen of typhoid, influenza and similar semi-infectious cases. This hopper is some improvement over the ordinary clothes boiler as it is close fitting and will stand 100 pounds steam pressure. This is done for the protection of the laundry workers, as the linen is again sterilized in the regular laundry process. The same system is used in the wing for contagious diseases.

In all these and many more ways, our high pressure steam system is a pleasure and a joy forever. It is practical, flexible, efficient and no more expensive than any other system. We hope that hospitals that are in doubt in the matter may profit by our experience and be saved our travail of experiments and expense.

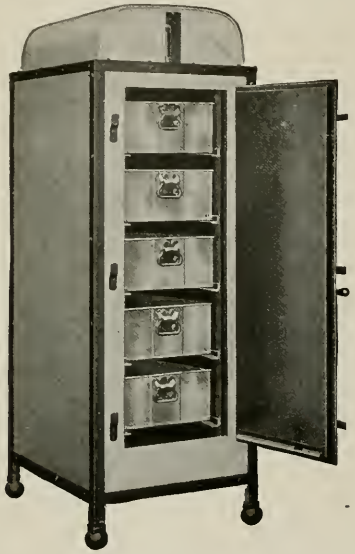
FIGURING THE COST OF CHARITY

The monthly statement of Presbyterian Hospital, Chicago, shows at a glance how much charity is costing the institution. Whenever a charity patient enters the hospital and is given a $5 bed, he is charged on the books at the rate of $5 per day, an entry noting that he is a free patient. The hospital works on the theory that the charity patient is taking away the $5 daily which the institution could properly earn and so the service rendered him is entered on the books and charged off to charity.

LOW TEMPERATURE COOKING

Although the claims made by the manufacturers of a new low temperature cooking apparatus may appear revolutionary, yet this new process represents the results of more than twenty years' study and research and is successfully used not only in a number of well known hotels and hospitals but by the leading packers of the country in preparing food products for the market.

It must be emphasized in the first place that this new device is not a steam cooker as the cooking is not done under pressure but is accomplished at a temperature of 160 to 205°, depending upon the food that is being prepared.



Briefly stated the principle of the new cooker is 100 per cent saturation of the air in the cooker through the admission of live steam. The fact that the air is thoroughly saturated prevents evaporation of the food and thus allows it to retain all the natural flavors and juices and prevents the loss of weight, particularly in meats, through evaporation. Several types of these cookers are offered, one designed for meat, another for miscellaneous vegetables and the third solely for potatoes. Steam, at from three to five pounds pressure, is gradually admitted through a thermostatic control which allows only the necessary flow of steam into the cooking chamber. The steam is thoroughly filtered before it is allowed to enter and it completely saturates the air throughout the cooking chamber. As the thermostatic control prevents excess saturation, there is but a very slight condensation.

Dietitians are agreed that high temperature, particularly dry hot temperature in excess of 182° F., tends to harden the albumen, particularly in meats, and causes a shrivelling of the meat, evaporation of the juice and the subsequent loss of both weight and flavor.

In this new cooker it is claimed that the weight of the cooked meat is the same as the raw meat placed in the cooking chamber, an indication of a very considerable economy. In addition the saturated air and slow cooking make tough meats tender and thus permit the use of cheaper cuts.

In the vegetable cooker a number of pans or containers are provided, each divided by a partition, so as to permit the cooking of as many as six different kinds of vegetables at one time. The complete saturation of the air insures retention of the natural flavor of each vegetable and prevents contamination with others. In vegetable cooking a maximum temperature of 205° F. is employed and this low temperature retains all natural salts that are found in the vegetables. Nor is there the flavor or odor of steam so frequently noticeable when vegetables are cooked above the boiling point under pressure.

The cookers are of a compact and attractive type. The cooking chambers are heavily insulated and retain all the heat which is furnished by the steam without radiation of heat into the kitchen.

The fuel cost is less than one-half cent an hour and the cooker can be operated either from a steam line or, if necessary, from an auxiliary steam generator because of the very low pressure required. The cookers are constructed of heavily galvanized iron, finished in luster enamel, which is not only rust proof but is easily cleaned.

Naturally a low pressure cooker of this type is lower priced than pressure cookers, owing to the difference in construction needs.

VISIBLE CLINICAL RECORD

A unique device was exhibited at the recent A. M. A. convention in St. Louis, which promises to fill a want long felt by hospitals. It is termed a "Visible Clinical Record" and consists of an improved chart holder with a rack for holding a number of them.

The chart holder itself is constructed entirely of aluminum, with rubber endcaps to obviate noise and prevent marring furniture. The holder when opened, stays open, greatly facilitating the arrangement of sheets, which are further secured by being placed over two posts projecting from the back of the holder.

A card holder on the front provides a space for the placing of a slip bearing the patient's name and room number, together with the name of the attending physician. This is visible when the holder is placed in the rack.

The rack is constructed to provide for ten or twenty holders, but may be increased to any desired extent by adding more units. It may be hung on a wall, used on an

ordinary table or desk, or set flush on a specially constructed desk.

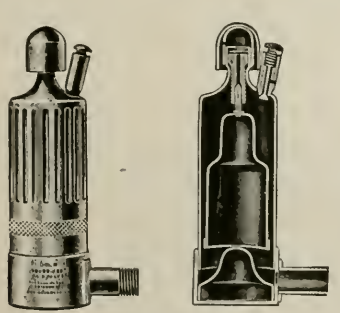
The accompanying illustrations give a good idea of the practical use of this device.

THE IMPORTANCE OF AIR VALVES

Few hospital superintendents fully appreciate the importance of proper air valves for the successful operation of their heating system. Yet, probably no other small detail connected with the heating system exercises so marked an effect on the satisfactory operation of the complete system. In fact the development of modern heating systems may be said to parallel very closely the development of the air vent valves.

The fact that the air valve is readily replaceable has prompted owners of obsolete heating systems to replace the old style valves with modern types, greatly improving the working efficiency of their heating system.

The original air valve was hand operated and while simple was quite successful, provided the persons in charge did not become forgetful and leave the air vent open, causing considerable damage and loss. From the hand operated air vent came various developments of automatic air valves.



One of the earliest of the automatic valves was designed according to the principle that carbon would expand and contract from the action of heat and cold. In this valve a carbon post was installed providing an automatic opening and closing of the air valve according to the heat in the system.

The earlier valves of this type had no provision against cold water flooding, but this was finally overcome in the hollow float containing the carbon post on the inside. While this valve proved quite successful it was easily damaged and put out of order.

The next step in the development of air valves was the introduction of what is now known as the thermostatic or all-metal air valve. The expansion liquid upon which the action of the valve was based could be absolutely depended upon to expand with heat and contract as soon as it cooled below a certain degree. This method also permitted tempering the liquid to bring it to the predetermined point of contraction and expansion necessary to the effective operation of an automatic air valve.

Various types had been placed on the market, all efficient and good, but there still remained some obstacles to overcome. One of the greatest of these was the fact that an air valve, being located at the extreme end of a radiator or coil, was subject to flooding with cold water as soon as the pressure was turned on. When the valve was flooded, it naturally raised the float. This sealed the valve preventing the leakage of water; thus was formed a partial vacuum in the top of the air valve which prevented the float from falling. This meant sealing the valve and preventing the radiator from venting; the system thus became *air-bound.*

Different methods had been adopted, more or less successfully, for the purpose of draining this water, but still the fact remained that some means must be found to break the vacuum forming in the top of the air valve so as to permit the water to flow back freely into the radiators.

One of the leading manufacturers of valves in the United States has recently placed upon the market an air valve, built on the most modern lines, wherein the expansion liquid referred to is placed in the float of the valve, the bottom of which consists of a finely tempered spring bronze diaphragm, convex in shape.

As soon as the air is expelled from the system, the heat causes the liquid to expand, pressing on the diaphragm referred to, raising the float and sealing the valve.

This company has also provided a means of draining the valve against flood, by incorporating a small hand-vent at the top of the valve. All that is necessary is to touch this vent when the air enters from the top and the vacuum is broken. The water immediately flows back into the radiator.

The success of this valve and the method of its construction has proved that an ordinary, one-pipe system can be successfully vented automatically. Practically all the numerous obstacles that manufacturers have had to contend with since the introduction of steam have been overcome.

RADIOS IN THE HOSPITAL

The rapid advance in the development of radiophones and the establishments of broadcasting stations in every section has brought the new science into the hospital as a means of entertainment of patients. In some institu-

tions radios are used in convalescent wards with amplifiers and distributing horns so that every patient in the ward is given the enjoyment of the radio entertainment.

The illustration shows a typical radio receiving set as used in a private room for the individual patient.

PRESERVING FRUITS AND VEGETABLES

By HELEN P. TAYLOR, Assistant Dietitian, Rhode Island Hospital, Providence, R. I.

The Rhode Island Hospital has always paid some attention to the canning of fruits, but during the war the work was continued on a more extensive scale by including the canning of vegetables as well.

Each year the volume of food put under glass has been increased until last year the storerooms probably contained more home canned fruits and vegetables than could be found in any similiar institution. Over 42,000 pounds, net weight, represented the amount of food preserved by the hospital last year. This included, besides fruit and vegetables, a large amount of jelly and pickled goods.

Much of the canning is done in a special room that has been fitted up for the purpose, although a great deal of it is carried on in the main and pastry kitchens. There has been no installation of equipment which is not also available for other work when canning is not going on. Both the open kettle and the cold pack methods have been used. Two-quart jars are used almost wholly as they are the most convenient size for dining rooms and wards, although some vegetables for diabetics and other special diets are put into quart and pint jars.

It has been necessary to employ extra help to assist during the height of the canning season, but if, for a day or two, the canning activities are light these extra persons are utilized for extra work such as cleaning, etc. On days when the canning work is especially heavy, all other work is made as light as possible.

Vegetables and fruits are bought when the market is crowded and prices are low, so that with the low cost of the raw materials and the elastic method of handling it, the hospital gets a much larger quantity and greater variety of preserved foods than it would otherwise be able to purchase.

The assortment of foods canned varies a little each year, depending upon the season and the market, but there is very little pause in the canning work from the marmalade, rhubarb and asparagus in the spring, through the rush of string beans, tomatoes, peaches, pears, etc., of August and September, to the cranberries of November. Finally when the storage shelves are filled it is no small relief to the steward and the dietitians as well as the other workers if nothing more can be thought of to be put into jars.

VISITING NURSES' KIT

While there has been a number of outfits designed for the use of visiting nurses, the kit illustrated is particularly comprehensive and provides the equipment necessary for almost any condition.

This outfit was designed for the Pacific Hospital of Los Angeles to meet the requirements of the visiting nurse in the home or when called upon to care for the patient in a strange hospital. Although the hospital may be equipped with all necessary supplies such as are included in the outfit, it is extremely difficult for a strange nurse to locate these supplies and secure them promptly when needed. For this reason, the Pacific Hospital designed this special nurses' kit which is furnished to graduate nurses when going into other hospitals on special cases. With this kit in her possession, the nurse is not called upon to ask for every one of the common articles which she needs and is able to devote herself exclusively to the care of the patient.

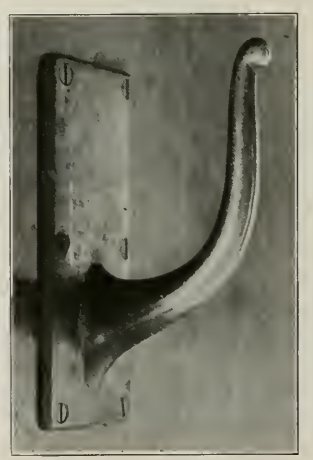
In the Pacific Hospital, the equipment belongs to the hospital and is simply loaned to the nurse who signs for the outfit when she receives it and assumes responsibility for any breakage or loss while it is in her care.

Although each hospital may have different ideas regarding the equipment, the outfit illustrated includes the following articles: Bed pan and cover, urinal, enema can and tubing, enema and douche tips, proctoclysis outfit, glass and rubber catheters, rectal tube, hot water bag, ice bag, emesis dressing basins, large and small pitchers, tray, medicine glass, medicine dropper, drinking tube, box of vaseline, and one drop light.

These are all packed in a fiber case 17½x15x6½ inches with a typewritten list of contents pasted on the cover.

IN PLACE OF A DOOR KNOB

For one, with both hands and arms full, to approach a closed door has always been an experience fraught with danger to both load and temper.



To overcome this difficulty a new form of door handle has been devised at the Royal Victoria Hospital at Montreal. It consists of a protruding hook, as illustrated herewith, around which nurse or surgeon may hook the arm to open the door. This handle is valuable for use after the hands have been scrubbed and made sterile.

"Observation may always be improved by training—to look is not always to see."—Florence Nightingale.

Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
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THE ACTIVITIES OF THE STATE AND PROVINCIAL SOCIETIES OF OCCUPATIONAL THERAPY

THERE is no greater proof of the steady growth and development of occupational therapy than the organization of state societies. The state is the logical unit of activity. It is small enough to keep in touch with individual workers and to promote occupational therapy according to local needs, and yet it is large enough to be a state power and through affiliation with the national society to be an influence through the country at large.

When a group of enthusiastic therapists find mutual interest and the solution of common problems in acquaintance and discussion, a state society is born. Organization brings power and inspiration. It provides lectures, meetings and library facilities, initiates legislation, and may even promote sales and purchases. These are not only opportunities which are inaccessible to individual workers but they strengthen the work with hospitals and doctors and arouse the interest of the public.

The American Occupational Therapy Association welcomes the organization of each state society with a twofold joy; first, because each society means a new and strong group of therapists, and the work in each community can be best furthered by those within it; second, because the American Occupational Therapy Association is a national organization and each new society, with its proportion of delegates, represents a new section of the country which influences the policy and adds to the power of the association as a whole.

As occupational therapy develops in this large country, the state organizations must more and more be looked upon as the unit of activity in government representation, extension and promotion. The American Occupational Therapy Association needs the widely scattered centers of state societies and it needs the strength and activity of these organizations just as the state societies need the unifying and coordinating of their efforts in the national organizations. The American Occupational Therapy Association makes possible the inspiration and the contacts of the annual meeting. The large organization stands back of each small effort giving it weight and prestige. The American Occupational Therapy Association can make available for local societies a national, if not international, knowledge of occupational therapy and closely allied interests. The national organization has such contacts as that of federal government, the American Hospital Association, the American Medical Association, the National Tuberculosis and Mental Hygiene Associations. It may keep on file at headquarters details concerning every worker, available positions, salaries, and state, county and municipal legislation, as well as civil service requirements.

Each therapist may serve best, and realize the greatest rewards in her community, with the assistance and backing of her state and national organization. Loyalty to one is not lessened by devotion to the other, as they work together, parts of a great whole, and service through the avenue of occupational therapy is expressed in both. —[Editor's Note.]

The officers of each society and a brief account of their work follows:

WHO'S WHO

Illinois—Psychopathic Hospital, Wood and Polk Streets, Chicago.
President, Katherine C. Staples; vice-president, Kathryn Bartlett; recording secretary, Grace Herbst; corresponding secretary, Lucille H. Guertin; treasurer, Winifred Brainerd.
Chairman of standing committees: Program, Mrs. Anna Tomkins; social, Mrs. Robert Kerr; membership, Marian Clark; auditing, Helen McNeal.

Manitoba—Psychopathic Hospital, Winnipeg.
President, Miss E. A. Griffin; vice-president, Mrs. J. P. Oliver; secretary, Mrs. B. Stewart-Hay; treasurer, Miss Josephine Hickie.
Board of management: Miss J. L. Billington, Mrs. A. Wood, Mr. W. J. Warters, Miss E. J. Buchanan, Miss J. H. Stewart, Miss M. W. Telford.

Maryland—Sheppard and Enoch Pratt Hospital, Towson.
President, Mrs. Marshall Price; vice-president, Miss Drevenstedt; secretary, Miss Mary Bean; treasurer, Miss Mary Rice.

Massachusetts—433 Boylston Street, Boston.
President, Dr. E. G. Brackett; vice-president, Miss Harriet A. Robeson; secretary, Mrs. S. Parker Bremer; treasurer, Mr. Herbert Nash Jr.
Board of managers: Dr. John D. Adams, Dr. Walter E. Fernald, Miss Marjorie B. Greene, Dr. Herbert J. Hall, Dr. John B. Hawes II, Miss Ruth Wigglesworth, Mr. Arthur L. Williston.
Director, Miss Harriet A. Robeson.
Chairman of standing committees: finance, Mr. Herbert Nash Jr.; bureau, Mrs. Horace Morrison; publicity, Dr. John D. Adams.

Michigan—Newberry House, 1363 East Jefferson Avenue, Detroit.
President, Mrs. William Burtenshaw; vice-president, Mrs. Pearl Potvin; secretary, Miss Camilla B. Ball; treasurer, Miss Lizette Hubel.

Missouri—3510 Washington Avenue, St. Louis.
Board of trustees: president, Dr. Malvern B. Clopton; vice-president, Mrs. Elias Michael; treasurer, Mr. John F. Shepley; Mrs. Lewis Gustafson, Mr. Robert L. Lund, Dr. Hanau W. Loeb, Miss Augusta K. Mathiew, Mrs. Sidney I. Schwab, Mrs. E. F. Wuerpel, Dr. Cleve-

land H. Shutt, Mr. George C. Hitchcock; secretary to board, Miss Loretta K. O'Gorman.
Chairman of standing committees: workshops, Mrs. Elias Michael; vocational training, Mr. Lewis Gustafson; industrial placement, Mrs. Sidney I. Schwab; publicity and legislation, Mr. George C. Hitchcock; medical cooperation, Dr. Cleveland H. Shutt; instruction, Mr. E. H. Wuerpel.

New York—203 East 21st Street, New York City.
Board of directors: president, Dr. Alexander Lambert; vice-president, Dr. William L. Russell; vice-president, Mr. James G. Blaine Jr.; secretary, Mrs. Cornelius J. Sullivan; treasurer, Mr. John T. Pratt.
Executive committee: chairman, Mr. Henry R. Hays; vice-chairman, Mr. J. Newton Gunn; Dr. William L. Russell, Dr. George O'Hanlon, Mrs. Cornelius J. Sullivan, Mrs. Howard Mansfield; secretary, Miss Meta N. Rupp; workshop director, Mr. George A. Rutherford; office secretary, Miss Ruth H. Emory.

Ontario—145 Yonge Street, Toronto.
Hon. president, His Honor the Lieut. Gov. of Ontario; Hon. vice-president, Sir Robert Falconer.
President, Miss E. D. Stupart; vice-president, Mrs. H. G. T. Haultain; treasurer, Miss K. O'Grady; secretary, Miss A. Marks.
Committee: Miss M. Langley, Mrs. M. L. Graham, Miss M. Orr, Miss M. Bickell, Miss L. H. DeLaporte.
Finance committee: convenor, Miss O'Grady; Miss C. MacDonald, Miss G. Degas; Miss E. Eastmure.
Information committee: convenor, Miss L. H. De Laport; Miss M. Macpherson, Miss C. Cavell, Miss I. Gorrie.
Publicity committee: convenor, Dr. George M. Langley; Miss F. Wright, Miss Orr, Mrs. E. MacMillan, Miss Leask.
Special committee: convenor, Dr. George E. Wilson; Dr. Cunningham, Dr. Goldwin Howland, Dr. J. H. Elliot, Dr. Grant Fleming, Dr. George Smith.
Branches of society: Hamilton, London, Kingston.

Pennsylvania—2200 Delancey Place, Philadelphia.
Temporary chairman, Miss Ida F. Sands; temporary secretary, Miss Marian Monroe.

Washington, D. C.—St. Elizabeth's Hospital, Nichols Avenue and Anacostia Street, Washington.
President, Miss Elsey R. Taft; vice-president, Mrs. Frank Smith; secretary, Miss Clara Bell Davis; treasurer, Miss Marian Morris.
Directors: Miss Emily Haines, Mrs. Axel Sumner, Miss Alberta Montgomery.

Wisconsin—Columbia Hospital, Milwaukee.
Executive officers: honorary president, Dr. F. J. Gaenslen; president, Miss Hilda B. Goodman; vice-president, Miss Mabel Frame; secretary, Miss Irene Grant; corresponding secretary, Miss Ruth Wilson; treasurer, Miss Elsa Dudenhoefer.
Chairman of committees: publicity and legislative, Mrs. C. H. Davis; training and requirements for teaching O. T., Miss C. Partridge; extension, Dr. Pleyte; medical and hospital advisory, Dr. O. Lotz; magazines, Miss Heimbach; secretary, Miss Alice Ogden; library, Miss D. Brown; crafts and occupations, Miss Julia Hooker.

Illinois

During the past year the Illinois Society of Occupational Therapists has felt sharply the growing pains of youth. We have perhaps actually increased our stature little, but we have made one tremendous stride upward toward that goal in the development of occupational therapy for which we are striving.

Last year as part of our program we visited most of the Chicago hospitals having occupational departments, and it is needless to state the value and interest of such contacts to all members of the society. But though we gained much within our own group of active workers, we began to feel most strongly the necessity for enlarging our activities to include a closer cooperation with the other departments of the hospital and to bring the value of occupational therapy more forcibly to the attention of the medical profession and to the public at large. This need developed into the formation of a publicity committee which promises to achieve much towards these ends.

Occupational therapy has been too often an "extra" department in the hospital—a type of treatment not considered by the physician as a valuable factor and not connected in any practical working manner with the other hospital units. We hope through our recent affiliation as an institutional member of the American Hospital Association to help accent the need for occupational departments to be more closely interwoven with the rest of the hospital scheme; to be not an interesting departure but a small essential part of the smoothly running hospital plan.

Our program for the coming year follows along the same lines of better coordination with affiliated fields in bringing to us as speakers:

Dr. Goodkind of Michael Reese Hospital.
Miss Boyd of the University of Chicago.
Dr. Mock of St. Luke's Hospital.
Mrs. Eleanor C. Slagle of the New York Society of Occupational Therapy.
Mr. Owens of the Municipal Tuberculosis Sanatorium.
Miss Weil of the Spaulding School for Crippled Children.
Mr. Worst of the Chicago Public School System Manual Training Department.
Miss Amelia Sears of the United Charities.

Through the suggestion of Dr. Mock we have availed ourselves of the privileges of the Hospital Library and Service Bureau, finding it both convenient and pleasant to hold all our business meetings there, and are now looking forward to some new plans for publicity which we hope to develop through the medium of this organization. —*Secretary.*

Manitoba

Manitoba commenced work in the Psychopathic Hospital in January, 1920; two aides began work at Brandon Mental Hospital in May, 1921, and the two military aides were retained at Selkirk Mental Hospital for civilian work. Occupational work was started by one aide at the new School for the Feeble-Minded at Portage la Prairie on April 1. In both Brandon and Selkirk the building plans include better accommodations for occupational work.

The Manitoba Society was organized in June, 1920, under the name of the Canadian Society of Occupational Therapy of Manitoba for the purposes of mutual improvement and exchange of ideas and of informing the public of the need of this work. At the beginning the society was composed principally of aides then in the employ of the Soldiers' Civil Re-establishment, and the Civilian Mental Hospitals of the Province, and later, as the associate membership extended, it comprised interested people of varying occupations, such as teachers, social service workers and others. The experience of many of the aides had impressed on them the need of a central city workshop for handicapped persons, both military and civilian, and to this end the efforts of the Society have been directed.

At the annual meeting in June, 1921, on account of invitations being sent to several hundred representative citizens, a much more widespread knowledge of and interest in occupational therapy was aroused.

The Society took a step in February, 1922, towards its objective of a workshop for handicapped by opening a room and equipping it for work and sale of products.

Maryland

The Maryland Society holds its meeting in the Medical and Chirurgical Building in Baltimore. It has been very fortunate in securing interesting speakers, such as the head of the Maryland Mental Hygiene Society, some special craft teachers from the Maryland Institute, representatives of the Public Health Hospital and heads of social organizations.

Massachusetts

The Massachusetts Association for Occupational Therapy held the first meeting in its proposed publicity campaign at the home of Mrs. L. Carteret Fenno, Boston, on March 14.

Dr. John D. Adams, vice president of the association and one of the founders of the war courses at the Boston School of Occupational Therapy, spoke on "Occupational Therapy, What It Is and What It Does." Dr. Kendall Emerson of Worcester, just returned from an inspection tour of European Hospitals for the American Red Cross, had for his subject "Occupational Therapy in European Hospitals." Dr. Frederick J. Cotton, realizing that occupational therapy is no longer confined to the treatment of the ex-soldier, spoke most interestingly on "The Value of Occupational Therapy to the Disabled in Industry."

There were more than two hundred persons present and the interest created by the meeting is clearly demonstrated by many new memberships to the association and by visits to the Bureau of Occupational Therapy.

The Bureau, established in 1920, has been taken over as an activity of the Massachusetts association. It has a four-fold purpose:

a. To be a center where information and designs relative to handicrafts may be had and where exchange of ideas will be welcomed.

b. To buy materials and equipment for departments and individuals making it possible, in spite of small commission charged, to deliver at less than retail prices.

c. To sell the finished product submitted by hospitals, institutions and individuals.

d. To promote service and understanding between the worker and the purchasing public.

The registration department is open for the registration of all aides meeting the standards of training and experience required by the Massachusetts Association. The Association is the only one at present requiring definite standards for aides; because of this it is believed that registered Massachusetts aides will have wide recognition.

Close touch will be kept with available positions and help will be given in placing registered aides.

Meetings are to be held in cities and towns throughout the state with the purpose of establishing sub-committees of publicity representing active centers of interest. It is hoped through these centers to have in organizing occupational therapy departments in the hospitals and institutions in their communities.

A survey will be made of all existing occupational therapy work in Massachusetts for:

a. Coordination of all allied interests.

b. The study and guidance of the future growth of occupational therapy.

c. The establishing of state standards for salaries of aides and occupational therapy records and charts.

Michigan

The annual meeting of the Michigan Association of Occupational Therapy was held on March 14 at the residence of one of the members in Detroit. The particular feature of the meeting was a lecture by Miss Kalb on dynamic rhythmics. She discussed the principles in abstract design for the crafts of occupational therapy.

The Detroit Chapter of the American Red Cross made a two-year demonstration with a shop for the handicapped of the city at Newberry House. During the time the Red Cross shop was in operation, approximately 250 patients worked in the shop. The patients were either blind or crippled, and many of them were quite old. Two busses were maintained for the transportation of the helpless cases. The patients received twenty-five cents an hour in remuneration for their effort in the shop.

During these two years the following activities were developed: weaving, basketry, sewing, Braille, typewriting, carpentry, brush-making, rug-making, chair-caneing, both machine and hand, chair-repairing, upholstering, toymaking, refinishing furniture and metal work.

The Red Cross closed its demonstration last June, and gave the patients a farewell party at Belle Isle.

In January the Junior League of Detroit took up the work with the handicapped, and a program is being developed for further work.

Missouri

The Missouri Association for Occupational Therapy was formed and incorporated June, 1919, for the purpose of introducing and extending the use of occupation as a curative measure, and for the organization and management of various activities for the promotion of the economic and individual betterment of the physically and mentally handicapped. In order to carry out the purposes of the Association the following activities were deemed necessary:

1. The training of teachers of occupational therapy.
2. The establishment and direction of curative workshops and bedside occupations in hospitals and dispensaries.
3. The organization and maintenance of an agency, or cooperation with existing agencies, for the vocational retraining of the physically and mentally handicapped.
4. The maintenance of, or cooperation with, a bureau for the industrial placement of the handicapped.

It is the policy of the association to appoint standing committees from among its members which have the direction of these various activities, the chairman of each committee being a trustee of the association, reporting at each regular meeting to the board the action of the committees and making such recommendations as require action by the board.

The board of trustees of the Missouri Association for Occupational Therapy feels confident that the work it has undertaken is capable of arousing an enthusiastic interest in all those who can be brought to understand its purposes and the beneficial results to be accomplished. The Association desires primarily to stimulate an interest in

A FORUM FOR STATE SOCIETIES

There are eight state occupational therapy societies in the United States, two provincial ones in Canada, and one in the district of Columbia. The state associations have many interests and problems in common, which may be best served by an interchange of ideas, experiences and experiments. There will be a column in THE MODERN HOSPITAL *each month hereafter devoted to the interests of the state societies entitled "The Roll Call."*

What would you like to know about forming a state society, and what would you like to know of the activities of other states? Write to the editors of the occupational therapy department and your suggestions and the answer to your questions will be printed in "The Roll Call."

This number will introduce the societies and will be a "Who's Who" of officers and committees. A brief account of the work of each society is being given.

its activities and to depend for its financial support on those who are genuinely interested and who are willing to make an effort to see the objects of the Association successfully accomplished.

New York

The New York Society is concentrating its efforts on the curative workshop and an eight-month training course for aides to begin in the fall. It will continue its registry of occupational therapists and the advisory service which it has been doing in the past.

A brief summary of work up to March 1, 1922 is given by the secretary: "We have registered 187 occupation therapists and placed eighty-six. These workers are trained occupational aides who give occupations to handicapped and ill people as a curative agent.

"We have had 129 requests from hospitals and sanatoriums for teachers and have filled eighty-six of these positions.

"Last summer, the Society directed a six weeks' graduate course in occupation therapy which was attended by twenty teachers, sixteen of whom are filling positions.

"During the past year, our visiting teachers instructed seventy-five home-bound cripples in occupation therapy.

"The Society has made recommendations for and organized twenty new departments of occupation therapy.

"We have recently completed a survey of the home-bound invalids in the East Harlem Health Center previous to starting work in that district.

"We have started a convalescent curative workshop at 203 East 21st Street for the discharged hospital patients unable to take up his or her former trade or sufficiently recovered to be retrained in a new one. The shop is conducted entirely on curative lines, and we demonstrate the value of occupation therapy as the link between the hospital and industrial training. Before assigning a patient to any definite work we require a record of the case and suggestions from the doctor who has the case under supervision as to the type of work best suited to the patient's needs. The workshop is under the supervision of the medical members of the committee and reports of the patients' progress will be rendered from time to time to the doctors referring cases.

Ontario

The Ontario Society of Occupational Therapy was formed in 1920. During the two years it has been in existence it has grown steadily in size and strength. It includes branches in Hamilton, London, Ottawa and Kingston.

The meetings consist of a business discussion, a lecture by some prominent person, and a social chat over a cup of coffee. Several trips have been taken to institutions of interest, including the Royal Ontario Museum and the Provincial Asylum.

Last year the season was closed by a reception at Government House given by His Honor the Lieutenant Governor of Ontario for members of the Society and their friends. Although the weather was exceptionally severe there was an attendance of some 500 enthusiastic persons.

The activities this season have been marked by a course of lectures and post-graduate work for those now in a hospital.

The chief work undertaken this year has been the development of a community workshop to take the place among civilians which the vet craft holds for disabled soldiers. Our hopes are to be realized and in a short time the workshop will be an actual fact. Our most prominent doctors and business men are completing the details of its preparation. Then our Society will have a home of its own.—*Secretary.*

Pennsylvania

On Thursday, April 27, a number of the occupational therapists of Philadelphia were called together to discuss plans for an association to discuss various problems that are developing in the work.

Miss Ida F. Sands, director of the occupational therapy department of the Philadelphia General Hospital, was appointed temporary chairman and Miss Marian Monroe of the Visiting Nurse Society, temporary secretary. After some discussion it was decided that this association of aides should meet on the fourth Thursday of each month at the Philadelphia School of Occupational Therapy. A nominating committee was appointed consisting of three members, and Miss Fulton, dean of the Philadelphia School of Occupational Therapy, was appointed chairman of the program committee.

Washington

On March 7 was held one of the most interesting meetings of this organization for the year. It was held at Walter Reed Hospital and was largely attended. The program was opened by Major Sherwood, director of Occupational Therapy at Walter Reed, and he gave a sketch of the history of the work there. There were two papers by Captain Pratt of Kankakee, Ill., and Dr. Robert Turnstall Taylor of Baltimore. The other able address was given by Dr. William A. White of St. Elizabeth's Hospital, in which he brought out many practical points in the application of occupational therapy to psychiatric patients. After the program the audience was invited to a social hour in the workrooms where a special exhibit of the crafts was shown and refreshments served.

Wisconsin

The Wisconsin Association is making an effort to extend occupational therapy throughout the state and to keep isolated workers in touch with one another. At first a news letter was sent to the various workers, but it was soon realized that Wisconsin needed a real journal devoted to local and state activities. The chief activities of the Association during the year have been the publishing of the *Journal*, a large meeting open to the public and a lecture course for the members.

On January 20 and 21, members of the Illinois Society were the guests of the Wisconsin Association. The Junior League of Milwaukee entertained the guests at luncheon. Mrs. Walter Bartlett gave the welcome, followed by a response from Miss Katherine Staples. Mrs. C. H. Davis spoke on the National Association and the relation of state societies to it.

A visit to the training school at Milwaukee Downer College followed the luncheon, after which the guests were entertained at tea at the nurses' home of Columbia Hospital. Miss Mary A. McMillan, superintendent of nurses, Presbyterian Hospital, Chicago, and Miss Titus of Columbia Hospital spoke on occupational therapy in connection with nursing problems.

An open meeting was held in the evening at Milwaukee Downer College at which Dr. John Coulter and Dr. Ethan Allen Gray of Chicago spoke. Miss Goodman staged a curative workshop clinic of paralytic children which brought to the public, as nothing else could, the great work of functional restoration for the little ones.

The *Journal* will be sent upon request to any state association.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association, 370 Seventh Avenue, New York

HUMANIZED SERVICE COUNTS*

BY B. C. ROLOFF, SECRETARY, ILLINOIS SOCIAL HYGIENE LEAGUE, CHICAGO

LET'S humanize our clinics. I'll admit doctors alone cannot do it. Their minds are too scientific. Don't think I hesitate to tell you medical men these things; there are sixteen good men and true on our staff and they hear it from me regularly. But a clever medico-social worker can mean the difference between success and failure in a clinic. Tact, kindness and diplomacy are essential. Our records are not as complete as they should be. We are rushed as other clinics are; our space is at a premium; our staff is limited; but we find that we can get lots of facts—not in a regular interview, but just in between. Hardly an old patient comes in who is not inquired about kindly every time he comes—his family, his work, his ailment. Oftentimes I slip out of the treatment room and jot down a bit of helpful information secured in that way.

We have simplified our follow-up in this way: Every patient is checked through a cash register. That machine is part of our bookkeeping system. I have seen doctors throw their hands up in horror at that cash register.

024 MAY 22 Figure at top is your number for this Clinic only. *B-.00 Leave this slip at downstairs desk on way out. (over)	OUR PATIENTS are entitled to the best possible scientific care and friendly treatment. If dissatisfied, tell the Superintendent. In return, please follow our Physician's instructions exactly. Ask the Doctor when you are to come back. ILLINOIS SOCIAL HYGIENE LEAGUE

It has even been made the subject of complaint at a medical meeting. But it serves a purpose far beyond the taking in of a little money. It is a part of our follow-up system.

The patient enters on his first visit. After the interview he is checked through the cash register whether he pays or not. The little slip that comes out is handed to him and he is told to return it to the admittance clerk before he leaves the clinic. After treatment is given, a new patient is likely to pass by the clerk, dropping his cash register slip, and start for the door. Right then and there begins our follow-up work.

"Wait a minute" calls the clerk, "What day did the doctor say you were to return?"

"Why, I don't know, I never asked him" is the reply almost invariably, even though the doctor actually *did* tell him when to return.

"Go back and find out," the clerk urges.

The patient seldom or never forgets after that to ask the doctor when he is to return. He cannot get out of the clinic without reporting the date of his next visit. This helps him to remember the time definitely. The clerk enters the date upon the little slip and puts it in the cash register drawer. The next day every one of those dates are entered upon the little square in the follow-up record with a single pencil line. Suppose that the same patient returns a week later, but not upon the right day. With the follow-up record before him the clerk asks:

"You were due to return here Tuesday. This is Wednesday. Why are you a day late?"

"Well, I had a date Tuesday."

Right then and there he gets a friendly admonition on the great importance of regularity in attendance and how much more quickly we can help if orders are obeyed. And that patient and every patient gets the same persistent pre-follow-up treatment, if I may coin a new phase.

At the end of the month all the cases that were due and did not come in that month are separated and gone over carefully. Those cases which are active and infectious are separated from the ones which have been discharged, given vacations, or who really should not be followed up. Letter No. 1 is written. It is on plain paper and is sent in a plain envelope. My own name and address are all that appear upon the notice. A curious landlady could steam the flap of such a letter and get nothing for her nosey curiosity. This protects the patient. The second letter is more urgent. The third is upon our letter head and frankly, but in a kindly way, threatens reporting the case to the health department.

Here are some interesting data on how our system works: In 1919 we had no social work.

December, 1919 out of 430 cases, 146 failed to return.

*Extracts from an address read before the Chicago Health Conference held under the auspices of the U. S. Public Health Service.

January, 1920 social worker engaged.
January, 1920, 549 patients treated, 154 failed to return.
February, 1920, 485 patients treated, 80 failed to return.
March, 1920, 595 patients treated, 48 failed to return.
April, 1920, 582 patients treated, 56 failed to return.
January, 1922, 600 patients treated, 8 failed to return.
February, 1920, 620 patients treated, 4 failed to return.

The first letter brings back 50 per cent of the cases absent without leave, the second 25 per cent more and the third 20 per cent more. About five per cent of those absent without leave do not come back.

The final follow-up is, of course, a health department job. If we know where a patient works, if he works, and it is easy enough to appeal to the employer, but that is seldom necessary.

In conclusion, let me say, human service pulls heart-strings. Any good clinic having good medical service, fortified by the right sort of social service, may secure the cooperation of the patient through the exercise of a bit of common sense and human kindness and make a success of its task—that of restoring to industrial and familial efficiency the unfortunate victims that come to it. Every clinic is a human repair shop. Our task is not complete when we merely sterilize a patient so as to render him non-infectious. We must do a complete job or the expensive medication and service originally given are almost wasted. We aim to keep our syphilitic patients in sight for five years. Our clinic is now treating case No. 8000 but cases Nos. 4, 36, 175, 200, 301, and many more, scores of them, are still coming either for treatment or periodical examinations.

HOLD REGIONAL DEMONSTRATION CLINICS IN NEW JERSEY

The Bureau of Venereal Disease Control of the New Jersey State Department of Health has just concluded a series of regional demonstration clinics in cities that maintain venereal disease clinics. These are Long Branch, Trenton, Salem, Jersey City, Atlantic City, Plainfield, Camden, Elizabeth and New Brunswick. The series began in Newark in May, 1921, and ended in Newark with the Public Health Institute in April, 1922. All venereal disease was considered, but syphilis was the chief subject. It is planned to emphasize the diagnosis, prognosis and treatment of gonorrhea in a repetition of the series of demonstration clinics next winter.

New Jersey has three thousand doctors. One-sixth of this number took the time and trouble to attend the meetings. Aside from proving the value to physicians of the demonstration of diagnostic and therapeutic technique, New Jersey proved to the hospitals and dispensaries and to health officers that *real service* by the local medical center to the physicians of the vicinity is not only utilized but enthusiastically welcomed by them.

In reporting upon the success of the year's work, New Jersey says:

"At all of the demonstrations the interest, attendance, and after effects, shown by personal letters, requests for consultation, history forms, etc., and increase in reports and laboratory examinations, indicated clearly the value of such meetings and convinced the bureau that the effort had been worth while.

"If there is not a considerable body of practicing physicians of a broad public health viewpoint, interested in the most effective methods for the treatment of syphilis, in sympathy with the program of the state venereal disease control campaign and convinced of the necessity of general medical examination of the collaterals of known cases of syphilis, much of the work of the state control bureau must be wasted.

"Of what avail is it to educate the public to seek examination if exposed to the disease and to seek treatment if the disease is found infective, if the practicing physicians of the state do not appreciate the value of the dark-field microscopic examination; do not interpret properly the Wassermann reaction; treat the diseases with substitute arsenical compounds of doubtful therapeutic value, or by mercury-by-mouth only; or pronounce the disease cured on insufficient evidence or before sufficient treatment has been given.

"A questionnaire was submitted by the bureau to the physicians of the state. This was answered by more than one-third of the physicians. A study of the answers indicates that very many who do not refer their cases of syphilis to syphilologists do give inadequate treatment and are not equipped to diagnose and prognose the disease properly. If any considerable percentage of these physicians have been induced to improve their methods of diagnosis, treatment and prognosis, the work has been of inestimable value.

"The increase in the reports from localities in which the demonstrations have been held, the increase in the use made of the state, county, and city hygienic laboratories, and the letters to the bureau from physicians, in reference to individual cases, are all indications of the value of the demonstration clinics."

The hospital, the dispensary, the health official, the medical society and the individual doctor can, must, and eventually will get together upon similar cooperative plans, which are bound to result in mutual benefit and increased better service to the community.

SEEK MODEL PEDIATRIC CLINIC

The Section on Pediatrics of the Associated Out-Patient Clinics, which in 1914 adopted standards for Class A, B and C clinics, was reorganized on May 10, 1922 with the following officers: chairman, Roger H. Dennett, M.D.; vice-chairman, William P. St. Lawrence, M.D.; executive secretary, Gertrude E. Sturges, M.D.; executive committee, Murray Bass, M.D., Stafford McLean, M.D., Marshall C. Pease Jr., M.D., Mark S. Reuben, M.D., Frank Howard Richardson, M.D., Louis C. Schroeder, M.D., Charles Hendee Smith, M.D. and the officers.

It was the opinion of the section that the grading of clinics by an approved standard would serve as a strong lever in the improvement of clinic service. The executive committee of the section was consequently instructed to proceed with the revision of the former standards and with the grading of the pediatric clinics represented in the association.

The desirability of a model pediatric clinic as a demonstration was also discussed. Since it was thought that the operation of such a clinic would be an excellent method of stimulating the improvement of pediatric clinics, it was decided that the section proposes the plan to the executive committee of the Associated Out-Patient Clinics and request funds to assist in such an enterprise. It was agreed that the selection of a place for the demonstration should be on a competitive basis, that the competition should be open to all member institutions of the Associated Out-Patient Clinics, and that the principles governing the selection of a demonstration site should be agreed upon in advance and made public.

MEETINGS, CONVENTIONS AND CONFERENCES

CATHOLIC HOSPITAL WORKERS HOLD ENTHUSIASTIC CONVENTION AT NATION'S CAPITAL

THE seventh annual convention of the Catholic Hospital Association of the United States and Canada witnessed the gathering of an enthusiastic group of Catholic hospital workers at the Catholic University, Washington, D. C., on June 20-23, 1922.

Following mass, of which the celebrant was the Most Reverend Sebastian G. Messmer, D.D., D.C.L., archbishop of Milwaukee, and a sermon by the Most Reverend Michael J. Curley, D.D., archbishop of Baltimore, at the Franciscan Church, the delegates adjourned to the auditorium of the university gymnasium where they listened to a brief, though happily phrased, address of welcome by the Right Reverend Thomas J. Shahan, S.T.D., J.U.L., LL.D, rector of the Catholic University of America.

Owing to delay in starting Tuesday afternoon's session, the Reverend Charles B. Moulinier, S.J. of Marquette University, Milwaukee, read merely the conclusion of his presidential address. He emphasized the thought that the Catholic Hospital Association is not only a scientific but also a religious and ethical body, devoted to organized service for the sick brethren of Christ, and that individual hospitals, to be successful, must be thoroughly organized and guided by trained personnel. While many of the activities of the hospital are easily understood and performed, there is much still to be learned, owing to the rapid progress of medicine. He, therefore, urged the delegates to take full advantage of the convention to gain added knowledge and inspiration through observing the demonstrations, studying the equipment on display at the exhibit and conferring with other delegates.

A symposium on hospital organization followed Father Moulinier's address. This consisted of a group of four brief papers on the scientific, economic and administrative organization of the hospital as a whole. The organization of the hospital as a whole was covered by Sister Amadens of St. John's Hospital, Cleveland, Ohio. Sister Amadens commented briefly on the components of a well organized Catholic hospital, i.e., the executive board, the advisory board, the sisters, the nurses, the administrative personnel and the hospital's obligations. Referring to the medical staff, she made a plea for the rigid exclusion of commercialism and the appointment of men of high ideals. To this end the members of the medical executive board must be men who can not only judge of the scientific ability of the members of the staff but who also have the ability to detect violations of moral standards. She also urged the appointment in all Catholic hospitals of an advisory board, composed of seven high class, capable business men who by the force of their personality, their acumen and their business contacts are well qualified to act in the capacity of advisers with reference to the business affairs of the institution.

Creating a Good First Impression

Sister Cephas, Mercy Hospital, Cedar Rapids, Iowa, who read the paper on "Scientific Organization of the Hospital," emphasized the importance of seeing that incoming patients are given immediate attention and that the feeling of antipathy toward the hospital which often exists is overcome by a spirit of kindness and cheerfulness. She deplored the bad impression made by many hospitals, the entrances to which are cheerless and barren. Necessary business arrangements, she observed, should be made in a pleasant, tactful manner, thereby avoiding the danger of having the hospital regarded as a mercenary institution. She urged the keeping of careful records of the scientific work of the hospital and cited examples of financial loss due to the lack of records.

Sister M. Innocent, Mercy Hospital, Pittsburgh, Pa., spoke on "The Economic Organization of the Hospital." She narrowed her subject down to a discussion of receipts and expenditures, purchase, personnel and equipment. Executives, she said, should see to it that all sources of revenue yield their full quota. Patients should pay one week in advance and when admitted should be informed as to extra charges in order to avoid misunderstanding and ill-will. She urged the adoption of the budget system as a sane and safe method of checking up expenses and advised the inclusion of an emergency item equal to ten per cent of the annual expenditure. As to purchasing she advised the Sisters to study the market constantly and intelligently and so far as possible to buy in large quantities. They should also take advantage of all cash discounts for prompt payment of bills. A well organized department of supplies, with a proper record system is imperative.

Speaking on "The Administrative Organization of the Hospital," Sister M. Regina, Mercy Hospital, Wilkes-Barre, Pa., said no hospital can afford to omit the education of the public as part of its function. The mistake of having professionally trained persons doing non-professional work should be guarded against. The governing board of the hospital should be well acquainted with the community it serves and should study constantly how best to serve it.

Sister Regina felt strongly that the medical staff should not be directly represented on the board. The hospital executive should be firm in putting policies through but she should temper her firmness with kindness and justice. She felt that the chief executive should have frequent meetings with her heads of departments. Superintendents of small hospitals, she felt, should meet patients on admission and every effort should be made to avoid treating them mechanically. Criticisms should be gratefully received but never taken at their face value. They should be investigated and, if found justified, acted upon.

The concluding paper of the afternoon dealt with the factors in the proper care of the tuberculous and was presented by Dr. Charles O. Giese, Glockner Sanatorium, Colorado Springs, Colo. Dr. Giese observed that while scientific men have thus far not been able to eliminate the source of danger in tuberculosis, nevertheless rapid strides have been made in providing facilities for the care and treatment of the tuberculous. He cited figures showing that whereas in 1905 there were but 8,400 beds for the tuberculous in the United States, in 1920 there were 41,544 beds. Yet with all these facilities not more than one in five or six can secure institutional care in any one year. The general outlook is encouraging and many are restored to lives of usefulness.

Tuesday evening there was a meeting of the officers and directors of the sectional conferences at which the Rev. George A. Metzger of Brooklyn presided.

The Thursday morning session of the conference was devoted to symposium on the fundamentals of medical activities and the functions of the general hospital.

Dr. B. F. McGrath, director of the surgical laboratories of Marquette University School of Medicine, Milwaukee, opened the discussion with a few explanatory remarks relating to a chart dealing with the functions of the general hospital, which was displayed on the platform of the convention hall. This chart brought out the central position of the patient in the scheme of hospital functions and showed graphically the relationships which the various factors of the hospital bore to him.

Following his remarks a series of fourteen ten-minute papers were read, explaining the various phases of hospital organization and administration.

The first address, delivered by the Rev. C. B. Moulinier, S.J., Marquette University, Milwaukee, dealt with the fundamentals of medical activities. Father Moulinier elucidated the chart, laying particular stress upon the thought that the hospital is in reality the laboratory where practical demonstrations of the first article of the Apostle's Creed are constantly being given. This, he says, gives the inspiration that makes science religious.

Must Take Part in Public Health Work

Speaking on extra-hospital activities, the Rev. John M. Cooper, D.D., of the Catholic University of America, contended that while the division of labor tends to make for isolation in the hospital field as elsewhere, hospitals cannot, with impunity, hold themselves in isolation, but must interest themselves in the general public health activities of the community they serve. They must interest themselves in the community's water, food and pure milk supply, in the problems of under-nourishment and industrial legislation, in housing, recreation and child care. To this end he suggested, first, that every hospital subscribe to two or three of the leading periodicals dealing with general public health and welfare movements; second, that the interest of the staff of the hospital be awakened to these movements; and finally, that each hospital have a representative actively at work in each of the principal social welfare organizations of the community.

In dealing with the subject of administration, Sister M. Beniti of Holy Cross Hospital, Salt Lake City, declared that the Sister Superior must know every detail of the hospital's activity and must bear the united burden of the entire hospital staff. Because of her position she should be consulted and considered by her aides, and no change in method should be made without her knowledge and sanction. In order to establish efficient hospital administration, Sister Beniti advocated the establishment of courses of study such as are now offered in industry for increasing personal efficiency. She felt that the administrative force of the hospital must coöperate closely with the medical and nursing staff and act not only as its directing, but also its encouraging and sustaining force.

Records as Instruments of Education

In the absence of Dr. G. P. Muller of the Misericordia Hospital, Philadelphia, Dr. F. D. Jennings of St. Catherine's Hospital, Brooklyn, spoke briefly on the administrative side of physiotherapy, as well as on the subject of staff meetings, records and museum. He made a plea for the wider introduction of physiotherapy into general hospitals in order to enable many patients, particularly surgical cases, to be returned to industry more rapidly. He emphasized the importance of adequate hospital records, asserting that the absence of records is analogous to owning a piece of land without possessing a deed. Not only must records be made, but they must be efficiently filed and used. The important thing, after all, asserted Dr. Jennings, is the man embued with scientific zeal and honesty behind the record. Records should be exact, terse, yet complete, and should contain a statement of end results. Records should not be inanimate sheets of paper, but active, pulsating instruments of education. The monthly staff meetings should not be primarily clinical; they should not be an attempt to duplicate county medical society meetings, but should be used to review the work of the staff. The staff meeting, Dr. Jennings held, is the staff mirror and is non-magnifying.

The triple subject of research, education and the hospital library was discussed by Dr. John T. Bottomley of Carney Hospital, Boston. Dr. Bottomley held that experimental and laboratory research was absolutely fundamental to medical progress; that research demanded minds, men and money and that the type of mind which could engage successfully in research work was very uncommon and was far from meeting the demand. Dr. Bottomley made a plea for the establishment of laboratory centers which would serve the diagnostic needs of the physicians of the community. He deplored the tendency to educate nurses far beyond actual needs and asserted that a far greater proportion of nurses should be trained to give service to the large group of people of moderate means. While he stood for the adequate education of all nurses, he was opposed to the overeducation of the large proportion of nurses. Special educational opportunities should, of course, be offered those who are to assume positions of unusual responsibility, such as heads of nurses' training schools. He held that every hospital, however small, should have a working library.

The subject of Dr. Raymond P. Sullivan's paper was "The Patient's Entrance." The patient, said Dr. Sullivan, will receive a favorable first impression of the institution if its admitting department has a dignified, orderly

Catholic hospital executives of the United States and Canada in attendance at recent annual session.

setting, is simple in arrangement and renders efficient service. A friendly atmosphere should prevail at the admitting desk. Unnecessary delays, should be avoided; attendants should be kind but firm, always remembering that the primary purpose of the institution is the care of the sick, that the patient is at the hospital by necessity and is entitled to efficient service.

The hospital as a diagnostic and therapeutic center was dealt with jointly by Dr. Charles Nielson, professor of medicine of St. Louis School of Medicine, and Dr. H. W. Loeb, dean of the same institution. The paper made a plea for the greater use of the hospital as a diagnostic center for the physicians of the community, especially in view of the fact that nowadays few physicians can afford to equip their private hospitals with the expensive appliances modern practice of medicine requires.

Speaking on the subject of psychiatry and neurology, Dr. A. C. Gillis, professor of neurology and clinical psychiatry of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, urged general hospitals to take a greater interest in the care and treatment of the thousands of psychoneurotic cases that might legitimately be admitted as patients.

Mrs. Agnes O'Dey, chief dietitian of Johns Hopkins Hospital, Baltimore, spoke briefly on dietetics, and urged hospitals not to leave the difficult problem of dietetics to chef or steward, however faithful he might be. All the food served in the hospital, and not merely that intended for private patients, should come under the surveillance of the dietitian.

Dr. C. A. Gordon of St. Catherine's Hospital, Brooklyn, dealt with the subject of post mortem examinations, and urged hospitals to make a determined effort to increase the number of their autopsies. In order that they may be more universal, many existing laws will have to be changed, others enacted, the opposition of undertakers broken down and prejudices of relatives overcome.

The early part of Friday morning's session was devoted to the reports of the chairmen of the various conferences held on Wednesday. The conference of Mothers Provincial and Superior went on record as favoring the eight-hour day for nurses and urged its early and general adoption. It also advocated the establishment of a school for the training of Sisters as instructors of nurses.

The conference of operating room nurses and anesthetists advocated the use of Sister anesthetists in the Catholic hospitals. The conference on laboratory directors and technicians favored charging a flat fee for the routine laboratory work of the hospital and additional fees for special examinations and tests. It urged hospitals to systematize their laboratory work to a greater degree than at present. It did not regard the training of Sisters as pathologists as a good plan. X-ray films, in its judgment, were better than plates.

The conference of the supervisors of records and their assistants felt the treatment sheet should contain the physician's original orders and should be filed with the hospital, that where interns are not available Sisters may take the histories, that when private patients are sent to the hospital the physician should send a copy of his history of the case, that operating notes should be dictated immediately following the operation, that records belong to the hospital and should be kept in its record room, that charts should be kept in the chart room out of reach of patients, and that a summary sheet is superfluous where the summary is made on the chart.

The conference of hospital service and dispensary workers urged the more general establishment of cardiac clinics along the lines laid down by the American Cardiac Association. It felt that the fees collected by the dispensary should be used for its upkeep, that student nurses should be given a brief course of lectures dealing with the scope and work of the social service department, that head nurses should notify the social service worker of the discharge of patients twenty-four hours in advance, that there is great need of more psychiatric clinics in general hospitals, and that the general lack of social service departments in Catholic hospitals is most unfortunate.

By a series of resolutions the convention went on record as follows: Although the association strongly urges the further organization of state conferences, this position must not be construed to mean the displacement of the annual convention of the association.

Hospitals should make every effort to instruct the clergy so that they may lead their congregations to take a more sympathetic interest in hospitals. The bishops were urged to give more consideration to hospitals and to appoint diocesan directors.

National Hospital Day was endorsed and members of the association were urged to participate in its observance. Congress was urged to allow the duty on surgical instruments to remain as at present, and at any rate not to increase it beyond three per cent.

The Gorgas Memorial was endorsed.

Before the convention closed Father Moulinier appointed a special committee to advise with the president relative to the reorganization of the association.

The commercial exhibit was an unusually complete one. During the convention the exhibitors held a meeting for the purpose of organizing a trade association which will have for its purpose better service to the hospitals.

The following officers were reelected: honorary president, Most Reverend Sebastian G. Messmer, Milwaukee; president, Rev. Charles B. Moulinier, Milwaukee; active vice president, Rev. P. J. Mahan, Chicago; secretary-treasurer, B. F. McGrath, Milwaukee; executive board, Dr. Louis D. Moorehead, Chicago; Sister Rose Alexius, Cincinnati; Mother M. Madeleine, Minneapolis.

The following trustees were elected to take the place of three whose term had expired: Rev. T. J. MacMahon, Regina; Rev. J. D. Sullivan, New Orleans; Sister de Pazzi, Chicago.

WISCONSIN, MINNESOTA AND IOWA FAVOR JOINT HOSPITAL CONVENTION

HOSPITALS of Wisconsin, Minnesota and Iowa will meet annually hereafter in a tri-state hospital conference, if action taken at the third annual convention of the Wisconsin Hospital Association meets with general approval. The convention was scarcely under way when the question of forming a tri-state convention was broached, expressions of opinion were sought and a committee of six, two from each state, appointed to consider the proposal and report their conclusions to the convention.

The committee consisted of Dr. Walter E. List, superintendent of Minneapolis General Hospital, and Mr. Williams Mills, superintendent of the Swedish Hospital, Minneapolis, representing Minnesota; Miss C. J. Garrison, superintendent of Sunny Crest Sanatorium, Dubuque, and Dr. F. E. Sampson, superintendent of the Community Hospital, Creston, representing Iowa; and Dr. William Kiley, superintendent of Columbia Hospital, Milwaukee, and Miss Johanna Mutschmann, superintendent of La Crosse Lutheran Hospital, representing Wisconsin.

Committee members met with Dr. A. R. Warner, executive secretary of the American Hospital Association, and on Thursday morning submitted a report recommending that a tri-state hospital convention be called annually, that the next convention be held in Minneapolis about the middle of May, 1923 and that Drs. F. E. Sampson, A. B. Ancker, W. E. List and Mr. William Mills be appointed a committee to make the necessary arrangements for this meeting. It was further suggested that the Minnesota Hospital Association resume its activities and that the hospitals of Iowa organize a state association.

Following the customary invocation and a brief address of welcome by Mr. A. A. Bentley, the mayor of La Crosse, the Rev. Hermann L. Fritschel, rector of Milwaukee Hospital, delivered the presidential address, in which he analyzed the hospital situation in the states of Wisconsin, Minnesota and Iowa, called particular attention to the fact that eighty-two per cent of the hospitals of these three states have less than 100 beds and made a plea for greater consideration of the peculiar questions and conditions that confront these institutions. The Rev. Mr. Fritschel outlined the proposal for a tri-state hospital association, called attention to the advantages of such an organization and especially emphasized the fact that its formation does not necessarily imply the abandonment of the individual state associations entering into the arrangement.

In his report as executive secretary and treasurer Mr. H. K. Thurston, business manager of Madison General Hospital, sketched the history of the Wisconsin association since its inception on September 16, 1920, and reported a balance in the treasury of $413.28.

As Dr. A. R. Warner, executive secretary of the American Hospital Association, who was scheduled to deliver an address at this session was delayed in reaching La Crosse, the Wisconsin Hospital Association adjourned and the delegates including representatives of the hospitals of Minnesota and Iowa met as a committee of the whole and devoted the remainder of the morning to a discussion of the president's proposal relating to the organization of a tri-state hospital association. Dr. A. B. Ancker, Dr. Walter E. List, Mr. William Mills, Miss Harriet S. Hartry, Miss Adah H. Patterson, Mr. C. C. Jensen, Miss C. J. Garrison, Dr. William E. Kiley, Dr. Myron W. Snell and Mr. H. K. Thurston participated in the discussion. The consensus of opinion was in favor of the inauguration of such an association.

Nursing education and the American hospital, the relation of the superintendent of nurses to the superintendent of the hospital, the standardization of hospitals of less than one hundred beds and the Wisconsin law for the registration of nurses were the major topics discussed at the session of Wednesday afternoon.

The first subject was admirably presented in a well-thought-out paper by Dr. Richard Olding Beard of the University of Minnesota which appears in the department of nursing in this issue of THE MODERN HOSPITAL (page 48).

To meet the increasing demand for nurses of every description Dr. Beard in summing up the discussion of his paper outlined the following measures which in his opinion should be adopted:

1. The education of the people in the economy of a larger use of the hospital as the desirable home of the sick in which competent nursing can be secured.

2. The creation or further development in public or general hospitals of a division for per diem patients who are not indigent, but unable to pay more than a suitable per diem for hospital and nursing service.

3. The simultaneous discontinuance of a per diem service in private hospitals, where it cannot be economically supported, and the recognition that the role of the private hospital is that of an hotel for the sick, which should be

Hospital workers from three states gathered at La Crosse, Wis., at the annual meeting of the Wisconsin association, May 31 to June 1.

COMPLETE oral hygiene as practised by nurses and other attendants is not only recognized as good administration, but is a necessary precautionary measure adopted by medical directors, superintendents and superintendents of nurses in the safeguarding of patients.

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self-supporting but in which charges for paying patients should be graded to the accommodations desired, as they are in the hotel for the well.

4. The further development or extension under visiting nurses' associations and nurses' registries of the principle of hourly nursing service, under which graduate nurses may be furnished for periods in a day, commensurate with the patients' needs, at hourly charges.

5. The organization of nursing clinics by groups of graduate nurses, through which either office or home nursing for any required period may be secured. These clinics could be made cooperative alike for nurses and patients providing lesser living expenses for the one; and fees, susceptible either of increase or decrease according to the patients' capacity to pay, for the other. Such organizations should be under a business manager who would pay expenses out of, and collect fees into, a common fund, the net proceeds of which should be pro-rated to the members on a basis of hours of service rendered.

6. A suggested arrangement by which senior nurses in the schools might be assigned for brief periods of time, under the direction of a school supervisor, to private cases at moderate charge. He was inclined to believe that this would prove a good contribution to the education of the nurse.

Following Dr. Beard's paper Miss Ada Belle McCleery, superintendent of Evanston Hospital, Evanston, Ill., discussed the relation of the superintendent of nurses to the superintendent of the hospital. In her address Miss McCleary defined the superintendent of the hospital and the superintendent of nurses, and emphasized the dual function of the latter in her supervision of the care of the sick and the education of young women as nurses. She contended that the respect of the superintendent of the hospital and the superintendent of nurses for each other must be founded on character and ability. She enumerated the handicaps of the superintendent of nurses as petty annoyances, such as the giving of orders arbitrarily by the superintendent of the hospital without conference, and the lack of interest in the nursing problems of the hospital on the part of the board of trustees.

Miss McCleery made a plea that both the superintendent of the hospital and the superintendent of nurses should sit in executive session with the hospital's board of trustees. "Why," she queried, "should the superintendent of the hospital carry the message of the superintendent of nurses to the board of trustees? He or she might be incapable of interpreting it; he or she might forget.

In the absence of Dr. Frederick W. Slobe of the American College of Surgeons Dr. James L. Smith read Dr. Slobe's paper which was devoted to a discussion of the four minimum standards of the College now familiar to readers of THE MODERN HOSPITAL.

Tells of Nurses' Registration Law

The paper on the Wisconsin law for the registration of nurses by Miss Adda Eldredge, director of nursing education for Wisconsin, Madison, was moved forward from Thursday morning's session. Miss Eldredge traced the origin and evolution of the Wisconsin registration law and outlined what had been done in the state thus far and what it was hoped in time to accomplish in the way of stimulating enrollment in nursing schools, helping in the organization of new schools, securing properly trained superintendents of nurses and superintendents of nurses' training schools and elevating the general status of nursing work in the state.

The evening session of Wednesday was public. It was held at the Congregational Church and attended by about 200 persons. Dr. Walter E. List showed a motion picture of the work of the Minneapolis General Hospital, described on pages 347-350 of the April issue of THE MODERN HOSPITAL. Dr. List's picture was followed by an exceedingly interesting illustrated talk on plastic surgery by Dr. George V. I. Brown of Milwaukee. Dr. Brown brought home to his hearers the wonderful possibilities of the new art and science of plastic surgery, particularly as it has been developed during and since the great war.

The concluding address of the evening session was delivered by Dr. F. E. Sampson of Creston, Iowa. He discussed the community hospital in his well-known witty and incisive fashion, drawing heavily on various charts to clinch the points he sought to drive home. Dr. Sampson drew a picture of the chaotic, unorganized condition of the various public health and welfare agencies of the state of Iowa, and showed how they were gradually being organized into cooperating groups working for common ends under paid executive leadership.

Thursday morning's session was opened by a brief address by Dr. A. R. Warner, in which he advocated the organization of sectional hospital associations, comprising a number of individual state associations, that would be big enough to make live meetings possible and sustain the interest of the hospitals year in and year out.

Scope and Staff of Laboratory

The hospital laboratory was the subject of a well developed paper by Dr. T. B. Mageth of the Mayo Clinic, Rochester, Minn. The person who should be placed in charge of the laboratory, Dr. Magath observed, should depend on the type of work the laboratory does.

If the work is largely surgical then the laboratory should be placed in charge of a tissue pathologist; if largely medical, in charge of a clinical pathologist. In the smaller hospitals a laboratory technician, supervised by some doctor of the staff on the medical side, may meet the hospital's need. The actual interpretation of results should in all cases be done by someone trained in the field. The laboratory to do the work efficiently must be located in a suitable room, which is at least 12x16' in dimension. A room on the top floor of the hospital is to be desired and, if tissue work is to be done, preferably one near the operating suite.

In Dr. Magath's judgment the laboratory of the hospital of from fifty to 100 beds should carry on the following lines of work: tissue pathology, hematology, urinalysis, gastric analysis, stool examination, sputum examination, bacteriology and serology. He felt it is impractical for a hospital of this size to do its own Wassermanns. For this it should rely upon the board of health or upon a commercial laboratory. Attention was called to the difficulty of getting capable persons to man the laboratories, and Dr. Magath made the startling observation that out of 2,500 applications for fellowships at the Mayo Clinic only two applied for fellowships in pathology.

Speaking on the subject of the hospital dietitian Miss Addy I. Marlatt, director of the course in home economics at the University of Wisconsin, stressed the value of diet in the remedial care of the sick and observed that the most effective treatment of the sick is accomplished where the triumvirate of the physician, the nurse and the dietitian work hand in hand. Miss Marlatt pointed out that the dietitian must cover all of the food work of the hospital and to carry on her work efficiently must go with the physician on the wards and learn the reaction of the patients to the food served them. Where the dietitian

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does not visit the patient, cooperate with the doctor, and visit the clinics, she cannot do her best work. Miss Marlatt opened up great vistas of research in food that must still be explored.

Thursday afternoon was devoted to a brief address by Mr. Richard E. Schmidt of Chicago on "Hospital Architecture" and to a round table which in the unavoidable absence of Mr. Asa S. Bacon, superintendent of the Presbyterian Hospital, Chicago, was conducted by Dr. A. B. Ancker.

In his informal talk Mr. Schmidt touched upon some of the newer developments and features in hospital construction and called attention to the fact that whereas twenty-five years ago 6,000 cubic feet of air per patient was adequate, now 10,000 cubic feet is required in a well-appointed hospital, and often, when provision is made for future expansion with accommodation for nurses, as high as 12,000 or even 15,000 cubic feet may be required. Touching on the cost of construction he stated that twenty-five years ago it was possible to build a hospital for twenty cents a cubic foot, but in 1914 it cost thirty-five cents and in 1918 seventy cents. This year costs have dropped to sixty cents a cubic foot.

Suggests Economies in Construction

Mr. Schmidt said it would greatly simplify the problem of the hospital architect if there were more uniform methods of hospital operation, particularly of the food service, and suggested that a comprehensive study of food service for hospitals of different sizes be made. He said that the cost of a good dumb waiter for the transportation of food is now almost equal to the cost of an automatic elevator and told his audience that elevators can now be equipped with special levelling devices which will automatically bring them to the exact level of any floor. He urged the installation in hospitals of sound deadening devices and materials to minimize the noise of elevators and electric fans, etc. He also outlined a method he has evolved for protecting x-ray departments with four or five thin layers of lead foil, which can be applied by a paperhanger at about one-fifth the expense of the older method of having a plumber install sheet lead. He cited the growing use of friction hinges instead of door checks, hooks instead of door knobs, and called attention to a new double glass window in which the outer glass is held by means of a metal frame pressed against felt, and to a movable floor lamp for night service which has a round bottom and, though kicked, will always bob up and remain lighted.

Among questions discussed in the round table was the affiliation of general hospitals with tuberculosis sanatoriums. Miss Adda Eldredge, director of nursing education for Wisconsin, informed the delegates that the National League for Nursing Education advocates this affiliation and said that in her opinion poor housing and lack of proper supervision are the outstanding objections.

Answering the question of how complete a history should be taken of tonsil cases to satisfy the requirements of the American College of Surgeons Dr. Smith said a brief history that will justify the removal of the tonsils is adequate. He also feels that an examination of the chest and urine should be made, as well as a coagulation test.

On a show of hands it was found that fifteen of the hospitals represented at the conference discounted their bills before the fifteenth of the month. Answering a question as to the essential things to be considered at a regular medical staff meeting, Dr. Smith listed infections, deaths, unimproved cases and mistakes in diagnoses. In a discussion of laboratory charges a strong plea was made for a flat rate on the ground that it gives the hospital a clear idea of definite financial returns, puts the laboratory in the position of a producer and makes the doctors feel free to develop routine laboratory tests. Mr. Fritschel suggested the desirability of having all the laboratory work of the hospital supported by endowment.

Names New State Officers

Following the afternoon session the delegates were taken on a delightful automobile tour of the city of La Crosse and the surrounding country.

A commercial exhibit consisting of twenty-one booths was held at the Elks' Club Hall, next door to the Chamber of Commerce buildings.

The officers for the ensuing year are: president, Rev. H. L. Fritschel, director, Milwaukee Hospital, Milwaukee; first vice president, Dr. T. G. Meacham Jr., president of board, St. Luke's Hospital, Racine; second vice president, Dr. Myron W. Snell, surgeon, National Home, Milwaukee; treasurer, Mr. H. K. Thurston, business manager, Madison General Hospital, Madison; trustee for five years, Miss Shirley C. Titus, R.N., superintendent of nurses, Columbia Hospital, Milwaukee.

SANATORIUM ASSOCIATION VOTES TO MODIFY CLASSIFICATION

The American Sanatorium Association held its annual session this year in Washington, D. C., on May 3 with Dr. Lawrason Brown in the chair and Edward S. McSweeney at the secretary's post. The meeting was unusually large this year and the discussions widely participated in.

The convention voted that a committee be appointed to consider the present scope and activities of the American Sanatorium Association and to report at the next annual meeting on the desirability of reorganizing the association.

Another matter of interest in the convention proceedings was the adoption of the recommendations of the committee to include x-ray findings in the classification of tuberculosis. The proper classification of cases is especially important in a disease such as pulmonary tuberculosis where the varying conditions met with are not sharply defined one from the other, it was brought out, and it is absolutely essential to have some definite standard to insure that reports and descriptions of individual cases are in comprehensible language and carry a precise meaning. The classification in use came from the American Sanatorium Association as a modification of the Turban classification used abroad, and is used practically all over the United States. Modifications have been made from time to time, but only after careful thought. The present one has been under consideration for two years.

INDUSTRIAL PHYSICIANS MEET

The seventh annual meeting of the American Association of Industrial Physicians and Surgeons held in St. Louis, May 22 and 23, was more largely attended and far broader and more spirited in its discussions than any previous conference of the association. The addresses offered and the more important discussions will be passed upon for publication.

Officers of the association for 1921 were all returned by the convention. They are: president, C. E. Ford, M.D.; vice president, C. F. N. Schram, M.D.; second vice president, L. A. Shoudy, M.D.; and secretary-treasurer, W. A. Sawyer, M.D.

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Sugar	Vegetable Color	Sugar	Fruit Color
Water	Fruit Flavor	Water	Fruit Flavor
Fruit Acid	Gelatine	Fruit Acid	Pectin

You will notice by this table that the great difference is that Jell-O contains gelatine while ordinary jelly contains pectin.

Pectin is a substance contained in fruit juice. It is the element that causes the juice to "jell" when it has been cooked long enough. No particular claims are made for it as a food.

Gelatine, on the other hand, causes Jell-O to "jell" and is besides a valuable food element. Its importance is indicated by its extensive use in hospitals and in the diet lists prescribed for almost all conditions.

If you are particularly interested in these ingredients we suggest you write us for our complete Food Folder.

Yet Jell-O does not pretend to be a substitute for a fruit jelly. It is not so sweet but that children may eat all they care for. The amount of fruit acid (from grapes) is just enough to be palatable. The colors and flavors are so nicely balanced and measured that it is always beautiful to look at and delightful to the taste. Best of all *you'll like Jell-O after you have eaten it.*

The Genesee Pure Food Company
Two Factories
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HOSPITAL ASSOCIATION OF PENNSYLVANIA MEETS IN FIRST ANNUAL SESSION

WHAT has been officially designated as "the first annual meeting" of the Hospital Association of Pennsylvania was held in Harrisburg on May 18 and 19. Although the Pennsylvania association was founded as recently as December, 1921, it boasts of well over 100 members, most of whom were present at the Harrisburg convention.

Owing to the short tenure of the officers chosen at the date of organization, the convention unanimously voted their retention for the coming year. The date and place of the next annual session was left to the judgment of the trustees.

Because of the absence of Dr. Daniel D. Test, superintendent of Pennsylvania Hospital, Philadelphia, and president of the state hospital association, the convention found one of the vice-presidents, Dr. J. C. Biddle and Col. J. H. Bigger, in the chair at various sessions. A telegram of greetings from Dr. Test bespoke his interest in the meeting, and a complimentary message from the convention to him in California expressed the desire for his speedy recovery from illness and his return to the helm of the association.

Round table discussions at the convention seem to provoke debate of extraordinary interest on many state and local questions, particularly in reference to state aid for hospitals. Several addresses touched upon problems of vital concern to the institutions represented, as the ready after-discussion seemed to indicate.

Mayor George A. Hoverter of Harrisburg greeted the hospital workers as the convention opened at 10 o'clock on May 18 at the Penn-Harris Hotel, with Vice President Bigger presiding. Reports of committees consumed but little time and allowed the superintendents time to inspect the commercial exhibits.

Benefits of Cooperative Buying

Some advantages to the individual hospital in cooperative buying were cited in the first paper of the afternoon session, read by Mr. Philip Cross, purchasing agent for the Hospital Bureau of Standards and Supplies, New York. Among the benefits accruing to the hospital from its dealings with a central purchasing bureau, Mr. Cross discussed the following:

Lower prices obtained through buying in large quantities.

Savings in commissions and in expenses of shipping and handling.

Lower prices obtained because of the prestige and advertising gained by the sellers.

Saving effected by an experienced buyer.

Benefit of competition from the best sources.

Greater certainty as to a satisfactory quality of supplies.

Better standards established by cooperation.

Advantages of definite specifications.

Advantages of continuing agreements and saving in the labor of renewal.

Benefit of concentrating orders.

The Nurse as a Teacher of Health

"Public Health Aspects of Nursing Education" was the subject of an interesting paper presented by Miss Katharine Tucker, superintendent of the Visiting Nurse Society of Philadelphia.

"During the initial period in the nurse's training, she should see herself quite as much a teacher as a technician in the art of healing," said Miss Tucker. "The hospital can be presented to her not as an institution contained within four walls, but as a community agency—a tremendous health force projected into the whole life of a community, tied up closely in its purpose and functions with all other agencies working for health. In the consideration of any patient, he should be seen not only as he is in bed, but traced back to his home and thought of as a part of a family and of a community.

"Another very practical way of helping the student get the positive health approach is in terms of her own health. As she is made to feel her own responsibility toward keeping herself well, she will have become instilled with the importance of health promotion rather than cure only.

"In teaching practical nursing during the intermediate and junior year the student should be urged to think constantly in terms of getting the patient back to normal, not simply in making him comfortable. She should be taught to be observant of indications as to possible causes quite as much as of present symptoms. In her senior year it is essential that every nurse should be seeing and seizing her opportunity to protect the health of the public."

Sister M. Innocent, superintendent of Mercy Hospital at Pittsburgh, concluded the afternoon's program by a paper on "Team Work in a General Hospital."

The Rev. Sister brought out in her brief address that the same knowledge of organization and administration in the wise selection and the fixing of responsibility upon supervisors and heads of departments in the hospital is required as in any large corporation and that only as this ability exists in the superintendent is the organization successful.

The result of team work in all the departments of the hospital should be, according to Sister M. Innocent, that the patient will not feel he has lost his identity but rather that he is in the midst of a large family, every member of which is interested in doing his share to restore him to health.

Feast for Brain and Stomach

Occasion for social intercourse was given the delegates at the banquet on the evening of May 18 at which, as Toastmaster Biddle said at its close, there was a good feast both for stomach and brain. Gov. William C. Sproul who was to have been the guest of honor was compelled to be out of the city and he sent as his representative Gen. Charles A. Snyder, state treasurer, who set his successors on the program an example of after-dinner wit difficult to follow.

Representing Dr. Edward Martin, state health commissioner, who could not fill his place on the program was Col. McClain who sketched some of the difficulties which confront the country doctor.

"Much of the unrest in the medical profession today," asserted Col. McClain, "is due to the fact that the bedside doctor realizes he is not well prepared. The days of treatment, the days of allaying symptoms without finding out the cause are gone and the country doctor wants to go where medical facilities are, where he can learn how to be a diagnostician. This problem must be solved by

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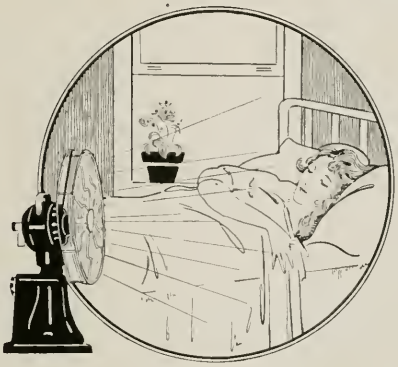

YOUR ROOMS, if properly ventilated, will take on an atmosphere of pure coolness—absolutely quieting to those who seek balm for their annoying pains and distorted nerves.

The modern hospital has been forced to make its rooms livable during the heated season. An electric fan motor operated on a systematic basis has been conceded to be the most practical and profitable method of serving hospital patients.

The Taxifan is now permanently installed in some of the most progressive hospitals throughout the country and its reliable and delightful performance is gaining for it increased popularity.

Your attention is directed to the slot attachment. The Taxifan will run one hour for each nickel inserted in slot—five nickels at a time, one after the other, can be passed through to obtain a continuous five hour run. Inside the coin vault is a cash register which accurately counts the revenue as deposited and relieves you of tedious bookkeeping.

It is manufactured and absolutely guaranteed by the General Electric Company.

Last shipments are now being completed. If you would avail yourself of the opportunity to install the Taxifan this season, telegraph collect for price quotations, etc. You will be allowed extended terms of payment.

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Exclusive Distributors **MEMPHIS, TENN.**

you hospital men by having your institutions so equipped that the doctor in that community can come into your hospital and learn how to make a diagnosis."

The feature of the evening's program was the able address on "The Recent Trend of Hospital Development" presented by Dr. Frederic A. Washburn, director of the Massachusetts General Hospital at Boston.

The hospital's obligation to the great middle class was stressed by Dr. Washburn. For them, he declares, hospital accommodations are inadequate and they must often be treated in their homes where physicians lack access to proper laboratory and scientific study. Sickness for them is a nightmare, for they are not only troubled by the disease and the question of its outcome, but their financial problem is grave and heavy. Hospitals must meet this difficulty for the good of society.

One General Hospital Usually Sufficient

So great is the cost of the modern hospital, said Dr. Washburn, that there cannot be extensive duplication. Only the very largest centers of population, in his opinion, should have more than one general hospital group. So also does the cost of modern methods and diagnosis make it impossible to duplicate facilities in any but the largest communities. Special departments of medicine are better handled as branches of a general hospital than as separate institutions.

Dr. Washburn strongly favors the teaching hospital and believes it is to the advantage of the well-to-do patients if the house officers and students have access to them and if they are subjects of the same keen study now given to the charity patients.

"The whole problem of the training of nurses is in a stage of transition. My personal belief is that it will be met by shortening a bit the general training so that a woman who has received this general training will be fit for bedside nursing and that special education in other branches of nursing will be a post-graduate affair given partly by the university, partly by the hospital or district nursing association."

"One post-war reaction, as it has affected hospitals, has been in many ways beneficial. There has been a tendency to question all existing things to find out whether they are done in the best way possible and, if not, to change them. In the days when hospitals cared for the poor only it was necessary for the large institutions to be heavily endowed or else have a considerable annual deficit. It was expected that the community would make up these deficits and the business management of the hospital was certain to go before the public year after year beseeching funds to pay off these large deficits.

"With the appreciation of the fact that it is the function of the hospital to serve all classes in the community, and with the change in spirit which makes all elements of the population turn to the hospital in time of sickness, has come a possibility of change in this financial situation. It is possible so to balance the building of your hospital that you will have the right proportion of patients who pay considerably more than cost, patients who pay cost and patients who pay less than cost.

The morning session on May 19, the second day of the convention, was given over to round table discussions on general hospital problems and on nursing questions; the former led by Dr. John A. Drew, superintendent of Chester Hospital, and the latter by Miss S. Lillian Clayton, R.N., superintendent of nurses at Philadelphia General Hospital. Of the two discussions, the nursing round table was perhaps the most productive and stimulating.

At the nursing round table, Miss Jessie E. Turnbull of the Elizabeth Steele Magee Hospital at Pittsburgh opened the discussion with a paper on the problems met in the general hospital of fifty beds and over. The small hospital's difficulties were discussed by Miss Edith E. Yingst of Carlisle Hospital.

The Pennsylvania inspector of training schools, Miss Mary, in concluding the round table declared:

"A hospital which does not have facilities to prepare its nurses for the care of both mental and communicable diseases, plus medical and surgical work, obstetrics, pediatrics and dietetics, is not sending women out properly equipped to take care of the public health. Unless we educate the young woman while in school to the needs of the mental hospital, to the needs of the children's hospital or the knowledge of taking care of children, she is not properly qualified."

Fair Play for the Intern

Opening the program of the final session was Dr. I. D. Metzger, president of the Pennsylvania Board of Medical Education and Licensure, whose address had to do with the hospital's obligation to interns. The Pennsylvania legislature was the first state assembly to pass an intern training act and is the only state which supervises its intern training.

"Certain things are demanded of the hospital for the intern. In the first place, he has a right to some place to sleep which is better than a basement. Then, I have heard complaints from some places that interns are not being properly fed; in other places they have no hours for recreation. The intern ought to be well housed and be given a good physical existence; if you are not doing that for him, you have no right to ask him to come. Remember these are potential professional men and they have as many social rights as have the superintendents of the hospital.

"In the second place, there must be a professional life worth while for him. Your hospital must have a staff that will see to it that his work is carried out carefully, systematically and efficiently. These things require a record system and care in the keeping of records which cannot be questioned. Then every new case that comes before him when he gets out in practice will be a case for investigation."

Baldy Emphasizes Credit System

Dr. John M. Baldy, chief commissioner of the Pennsylvania Department of Public Welfare, gave an interesting address on the relation of his department to the hospitals of the state.

"You have the benefit of being the first commonwealth," said Dr. Baldy addressing the convention, "of being the first group of hospital people to adopt clean, pure business methods in your institutions and you will remain before the country as an example in that matter. But if you, and if the American Hospital Association, stop with bookkeeping you are going to fail. Your own energies have been wasted, if you do not, as every other business house that has any right to be called a business house has done, establish a credit department, then you have spelled failure from the beginning. Your credit department is the keynote of the whole situation and with a properly conducted credit department and a proper bookkeeping system, the hospitals of the state of Pennsylvania, I am confident, will be able to be independent financially,—a thing they never have been before and never could have hoped to have been without it."

The final paper on the program was an able discussion of hospital dietetics by Mr. Elmer Matthews, superintendent of Wilkes-Barre City Hospital at Wilkes-Barre.

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CASTLE

The Surgeon and Superintendent were talking—

"Good morning, doctor. How are you?"

"Morning, I'm worried about those infections and I'm afraid of that sterilizer. What check do we have on it?"

"The nurse is very competent."

"I know that. I've talked with her, and she follows the directions on the wall. But are we sure even so? She opens a valve for three minutes after she gets up pressure, and thinks she creates a vacuum. But the gauge tells her there is only 6, or even 10, inches of vacuum; and it takes thirty inches to make a perfect vacuum. What becomes of the rest of the air?"

"Left in the autoclav, I suppose."

"Yes, and it is heavier than the steam and is compressed in the bottom of the sterilizer. We don't know whether it ever mixes with the steam or not. If it does, steam and air at 15 lbs. pressure are not as hot as steam alone at 15 lbs. pressure."

"Perhaps that accounts for our inability to melt controls in the bottom of the sterilizer. What had we better do about it?"

"First of all, we must have positive, not approximate sterilization. Now I remember the system the Castle people use. They make a great point of getting all the air out of the bottom of the sterilizer. They force it out by the pressure of the steam itself. They certainly know our problems, and I believe our new sterilizer shall be a Castle. Suppose you write them. Here is the address.

WILMOT CASTLE COMPANY, 1151 University Ave., Rochester, N. Y.

NEW ENGLANDERS ASSEMBLE IN FIRST ANNUAL CONVENTION

THE New England Hospital Association held its first annual meeting since its organization and recognition as a geographical section of the American Hospital Association on May 17-18 at the Boston Medical Library at Boston. A fruitful program was presented at the meeting and delegates seemed to find equal profit from their visits to various of the thirteen hospitals in the city which threw open their doors to the visiting executives.

Dr. Lewis A. Sexton of Hartford Hospital (Conn.) is the newly elected president of the New England association. Other officers named by the convention include: Miss Mary M. Riddle of Newton Hospital, Newton Lower Falls, Mass., vice-president; Dr. Nathaniel W. Faxon of Massachusetts General Hospital, Boston, secretary and treasurer; Dr. Joseph B. Howland of Peter Bent Brigham Hospital, Boston, trustee for four years; Dr. John M. Peters, Rhode Island Hospital, Providence, trustee for three years; Miss Rachel G. Metcalfe, Central Maine Hospital, Lewiston, trustee for two years; Miss Ida F. Shepard, Mary Hitchcock Memorial Hospital, Hanover, N. H., trustee for one year.

Following an informal presidential address by Joseph B. Howland of Peter Bent Brigham Hospital were heard the reports of officers and committees. Secretary Faxon's report showed that of the 191 persons in New England who are members of the American Hospital Association, 115 are members of the New England geographical section. Twenty-eight hospital workers not affiliated with the American association brought the New England total up to 143.

Demonstrates Lighting Effects

An outstanding paper in the convention was the first scheduled address by Mr. Alfred J. Hixon, president of the Hixon Electric Company, Boston engineers, on "Modern Hospital Illumination." His remarks took added value through a display of various light bulbs and the shades best adapted to directing and diffusing light. Members showed ready interest in the subject and for forty-five minutes plied Mr. Hixon with questions or discussed the solution of their own lighting problems.

A brief round table discussion took place before the morning session was adjourned.

Dr. Thomas S. Brown, superintendent of the Mary Fletcher Hospital at Burlington, Vt., and Dr. D. L. Richardson, superintendent of the Providence City Hospital, R. I., occupied the speaker's platform during the afternoon session on the opening day. Dr. Brown's paper on "The Hospital as an Educational Institution in the Community" contained much that was suggestive and inspirational. The discussion that followed brought up several new angles to the subject. As a pioneer in the study of contagious disease technique, Dr. Richardson talked on "Principles to Follow in Building Children's Wards and Wards for Contagious Diseases."

Round table discussion and a question box concluded the day's session.

Dr. Harold W. Hersey, superintendent of New Haven Hospital at New Haven, Conn. opened the program on the second day of the convention with a paper on the hospital laundry.

"The hospital laundry," said Dr. Hersey, "presents a problem the satisfactory solution of which calls for efficient organization of the laundry personnel, standardization of labor, a definite schedule, accurate records and efficient management, thus developing maximum results and minimum expenditure."

Dr. Hersey's paper began with the construction of laundries and carried on through equipment and methods. He urged the hospital executives to interest themselves in the activities of men interested in commercial laundries, characterizing them as a keen and progressive group of business men who are raising the laundry industry to a high standard of efficiency. Further emphasis was placed on the necessity of accurate records of laundry output so that the weekly expense can be analyzed. Computation of hospital laundry earnings in terms of charges made by the commercial laundry is not entirely satisfactory, in his opinion.

Nurses' Home Luxuries

"The Nurse's Home" was the topic assigned to Miss Grace Haskell, superintendent of Wentworth Hospital at Dover, N. H., for presentation. Her well prepared paper provoked lively discussion on what was entirely desirable and what was luxurious in housing students in nursing.

In discussing "Publicity for the Hospital" before the convention Dr. George H. Stone, superintendent of the Eastern Maine General Hospital at Bangor, said:

"If the street railway, telephone or some other public utility would shut down for a brief period, such a great clamor would immediately be aroused that steps would be taken at once by the public toward the prompt resumption of service. On the other hand were the hospital compelled through lack of funds to close even a part of its plant, such action would receive only passing notice and would be the subject of criticism that such curtailment was due to extravagance in administration, little realizing the severe blow which a loss of hospital service would mean to the life and health of the community.

"The best way to overcome this general lack of interest in some communities toward hospitals and their needs is an intelligent campaign of publicity and education. Such a campaign should be started not merely for the purpose of appeal for funds but should be kept up indefinitely for the hospital owes this information to the public from which it looks for its support. Such a campaign is bound to result in a better understanding generally of the public toward hospitals and in the end the hospital will be assured of better support."

Doctor Latimer of Wilmington had been long afflicted with a cough and an occasional hemoptysis. He entered into the American army as a surgeon, and served in that capacity till near the end of the war; during which time he was perfectly free from all pulmonary disease. The spitting of blood returned soon after he settled in private practice. To remedy this complaint, he had recourse to a low diet, but finding it ineffectual, he partook liberally of the usual diet of healthy men, and he now enjoys a perfect exemption from it.—Medical Inquiries and Observations (1809), by Benjamin Rush, M.D.

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STANFORD UNIVERSITY HEAD IS NEW PRESIDENT-ELECT OF A. M. A.

More than 5,000 physicians and surgeons attended the annual convention of the American Medical Association held in St. Louis, May 22-29. On only three previous occasions in the history of the medical organization have the 1922 figures of 5,174 been exceeded.

Dr. Ray Lyman Wilbur, president of Leland Stanford Jr. University, is the new president-elect of the association. Other officers chosen at the House of Delegates session on May 25 are: vice president, Dr. Willard Bartlett, Missouri; secretary, Dr. Alexander R. Craig, Illinois; treasurer, Dr. Austin A. Hayden, Illinois; speaker of House of Delegates, Dr. Frederick C. Warnshuis, Michigan; vice speaker, Dr. Rock Sleyster, Wisconsin.

New members of the standing committees placed in nomination by President George E. de Schweinitz and approved by the governing body are: Council of Medical Education and Hospitals, Dr. William Pepper, Pennsylvania; Judicial Council, Dr. J. H. J. Upham, Ohio; Council on Health and Public Instruction, Dr. Walter B. Cannon, Massachusetts; Council on Scientific Assembly, Dr. E. S. Judd, Minnesota.

The convention, among many outstanding resolutions, took action:

Appealing to Congress to provide sealed packages of whiskey of fixed standard and price for medicinal use only, or substantially to repeal the Volstead Act as it now applies to physicians,

Denouncing the Sheppard-Towner law as undesirable legislation,

Approving the organization of a women's auxiliary to the A. M. A.,

Extending its public health and preventive work by establishing a lay medical journal, to be in circulation before the next annual convention,

Protesting against the teaching of chiropractic to ex-service men at government schools and urging that vocational training in medicine be given in Class A medical schools,

Endorsing the "open door" policy on the part of all institutions carrying on vivisection for research,

Defining new principles of medical ethics,

Opposing all forms of state medicine, excepting such service as is provided by the Army, Navy and Public Health Service, and

Approving the Bursum bill providing treatment for disabled emergency officers who served during the World War.

Dr. A. D. Bevan of Illinois presented before the convention the report of the Council on Medical Education and Hospitals. The necessity of the hospital in medical practice was emphasized and special attention called to the need for the development of the community hospital.

"The solution of the hospital problem is the establishment of a hospital in every community where there are enough people to support it," says the report. "This hospital would enable three or more physicians to care for the patients in the immediate community and through the better roads and the automobile to reach patients in every outlying district promptly. In connection with this central community, outposts might also be established in smaller, outlying localities, where a physician of the staff might keep hours at regular intervals. This would enable him to look after the general needs of that community, to recognize cases requiring hospital attention and to arrange for the needed care. The solving of this problem does not mean retrogression in either educational standards or methods of practice; it means the recognition of new conditions in medical practice and the establishing of community hospitals whereby these improved methods will be brought within the reach of all the people, those in the smaller towns and rural communities as well as in the cities."

The Association is planning to establish a list, not only of those hospitals approved for intern training but also of those approved as nonintern hospitals, it was announced.

The rapidly increasing demand for interns was the subject of comment and as causes contributing to this demand were given the large increase in the number of hospitals and that fact that a larger proportion of hospitals are making use of intern service; this, in turn, was attributed to the better qualifications of medical graduates. A survey being made by the council of all clinics and institutions giving medical service to ambulatory patients shows that there are 1,150 out-patient departments, 800 independent dispensaries, and approximately 200 clinics conducting "group practice." Including all clinics having to do with ambulatory patients, there are approximately 4,500. Complete returns are expected to increase these figures.

The 1923 meeting of the American Medical Association will be held in San Francisco.

TWO ILLINOIS ASSOCIATIONS MAY MERGE

A referendum vote of the members will decide whether the Illinois Hospital Association and the Downstate Hospital Association of Illinois are to merge. This poll follows the decision reached by special committees from both organizations that no question of policy now exists which will prevent their junction.

Following the regular annual meeting of the Downstate Hospital Association which was held in Chicago on May 18, committees of the two Illinois organizations met in conference and agreed to submit the proposed coalition to the members of the societies for action. Letters sent to members will seek their approval or rejection of the issue. In case the majority vote favors the merger, a convention will probably be held in the autumn at which time a new organization will be effected.

The Illinois Hospital Association is mainly an organization of Chicago hospital workers, while the constituency of the Downstate Association is largely executives from outside that city. An effort to reconcile the two bodies has been considered for some time.

The meeting of the Downstate Association on May 18 convened at the Great Northern Hotel in Chicago and consisted of a brief business session, a luncheon, round table discussion and a short program. Dr. A. R. Warner, executive secretary of the American Hospital Association, addressed the convention on "The Geographical Sections of the American Hospital Association," which paper was published in the June issue of THE MODERN HOSPITAL. The round table discussion was led by Asa S. Bacon, superintendent of Presbyterian Hospital, Chicago, and concerned itself with general hospital topics.

The old officers of the association were reelected: President, George S. Hoff of Aurora; vice president, J. W. Meyer of Aurora; and secretary-treasurer, Clarence H. Baum.

The committee appointed by the association to meet with representatives of the Illinois Hospital Association was composed of J. W. Meyer of Aurora; Mrs. Burgener of Pekin; F. E. Butcher of Danville; and the president.

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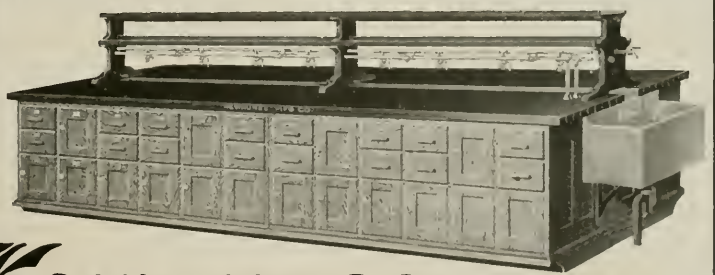

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Hints to Hospital Superintendents

PAINT FOR RADIATORS

The proper color for piping and radiators, in hospital or in home, is the color of the wall against which they stand, says George B. Hockel of Philadelphia, in an article of "Painting the Hospital" in a recent issue of *The Hospital World*.

"Who first conceived the notion that these, being made of metal, should be painted to simulate another metal, I do not know, but I do know that this happy thought has caused the ungraceful, if necessary, radiators in the land to stand forth conspicuous as fraudulent gold, bronze or aluminum creations that harmonize with nothing and interfere seriously with their only proper function," says Mr. Heckel.

In a metallic coating radiators do not give full efficiency by twenty per cent or more, according to tests made by the engineering department of the University of Michigan and by the Institute of Industrial Research at Washington.

The painting of radiators may materially affect the transmission of heat. A series of experiments were conducted two years ago to determine the effect of painting. Two cast iron rectangles were used; one was painted and the other left unpainted so that the painted radiator was always compared with the same unpainted radiator.

The radiators were first tested unpainted, and the condensation in the two were practically alike. One radiator was then painted with two coats of copper bronze and it was found that the heat transmission was reduced 24 per cent from the original cast iron. Two coats of terra cotta enamel were then placed over the four previous coats and the heat transmission was three per cent better than the original cast iron unpainted. This was repeated for fourteen coats, the last two being aluminum bronze. The transmission then showed a reduction of 27 per cent. In general, aluminum, copper and metal pigments in the bronzes reduce the heat transmission. Enamel lead paints and zinc paints almost all show no loss in heat transmission.

It is best to have all radiators painted with the same flat paint in the same tints as the walls behind them. One can see them without searching, but they do not assert themselves; and this, treatment has proved, is in every way satisfactory.

COURTESY ON FIFTH AVENUE

Hospital administrators in seeking to instill habits of courtesy in the personnel of their institutions will find that a high goal has been set for them by the Fifth Avenue Coach Company of New York. Bus drivers of this progressive transportation company have long been taught the value of courtesy as a business asset, and a recent analysis made of their individual records shows the following interesting results:

Men courteous under all circumstances.....98%
Men courteous under great provocation.....1½%
Men courteous under slight provocation.....½%

Even such a showing as the above was not satisfactory to the management and there has since been inaugurated a courtesy contest for the purpose of bringing the courtesy record up to 100 per cent.

CARE OF RUBBER WATER BOTTLES

Experts in the manufacture and sale of rubber hot water bottles say that deterioration is much more often the result of improper care than in the defectiveness of the bag. Cheap hot water bags retailed as seconds frequently last for many years while a high priced article may become dilapidated before a year has gone.

Probationers should among their earliest lessons be instructed in the care of hot water bottles. Deterioration may result from keeping the bag in too warm a place, in letting greasy substances stick to the rubber, in filling it with water which is too hot or in filling it too full. If there are defects in the rubber they will reveal themselves in a short time and reliable firms will replace the bottle.

The practice of placing a yearly guarantee on water bottles and rubber goods is manifestly unfair, according to dealers, and is being discontinued. The guarantee takes no account of the abuse to which the bottle may have been subjected. The fairest guarantee would be a broad agreement to replace the article if, upon return, it is found defective in either workmanship or material, whether the time is one, five or ten years.

WARD NO PLACE FOR GROUCH

The hospital ward is no place for the grouchy employe. In the Chicago State Hospital code, a book of instructions prepared and presented to employes, the following apt advice is given:

"Don't come on duty with a grouch. It is not the patients' fault that you have been up late the night before, have not eaten wisely, have had bad news from home or have quarreled with a friend. You are here to serve the patients and for no other reason. If you feel that you cannot do this properly or that the work is beneath you, this is exactly the time for you to seek some other employment or change your mind. This work, we know, is not all sugar and sunshine, but so long as you remain here it is work that is worth while, work that is worth an effort, and work that must be done, so: Keep a curb on your temper, soft pedal your grouch and be decent to the patients."

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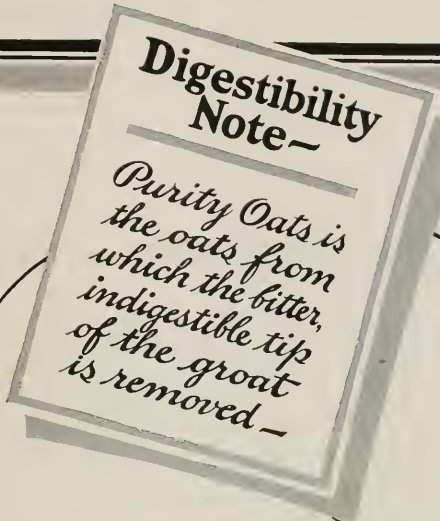

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than any other rolled oats,—because it is the only rolled oats whose every flake is a masterpiece of manufacturing. That is—no bitter, oily tip left on the groats, to interfere with digestion and make the product grow rancid. No hulls. No shorts. Rarely even a broken flake.

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Write on your hospital letterhead to the Purity Oats Company, Keokuk, Iowa, for the free hospital package. Try this totally different rolled oats.

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QUERIES AND ANSWERS

TEMPERATURE CONTROL OF HOT ROOMS

To the Editor of THE MODERN HOSPITAL:

By what means can the temperature and humidity of an incubator or hot room, designed for the occupancy of premature infants, be most satisfactorily controlled?

PEDIATRICIAN.

Such a room should have double windows and a vestibuled door. There should be an inlet for warmed air, which can be admitted by gravity and without any driving device, and there should be an exhaust ventilating duct—with which a slow running exhaust ventilating fan may be connected, if this is found to be necessary. If the highest degree of scientific construction is desired, the walls of the room may be insulated with cork. The room should be provided with a humidifying tank, in which steam coils are submerged. A thermostat and humidostat complete the outfit.

The principle of operation of the humidostat is the same as that of the thermostat, except that the thermostat contains a bimetallic strip composed of steel and brass which is affected by temperature. The strip either closes or opens a small air port, depending on whether the temperature rises or falls, and so opens or closes a steam valve, admitting steam to the radiator or excluding it therefrom.

The humidostat, instead of having a metal strip, has a wooden strip made of specially treated maple, and this wooden strip is affected by the change in humidity in the same way that the metal strip is affected by the change in temperature. The construction of the humidostat is in all respects the same as that of the thermostat; the humidostat operates a small valve which admits steam to the steam coils submerged in water in the humidifying tank. The steam passing into the coils causes an evaporation of water and increases the humidity.—S. S. GOLDWATER, M.D.

THE CARE OF TERRAZZO FLOORS

To the Editor of THE MODERN HOSPITAL:

Can you advise me as to what is best for cleaning terrazzo floors. I have tried several things but none of them has proved satisfactory. We take great pains to clean our borders and then after a few careless moppings by the janitor we have the same dirty margin along the edge. I shall be very grateful for any suggestion toward satisfactory care of there floors

SUPERINTENDENT.

Your problem is probably one of method rather than material. The "dirty margin along the edge" which you describe is a sign of sloppy workmanship. Any employe leaving a floor in that condition should be discharged. When it is so left there is only one thing to do: get down on the hands and knees and scrub it with a powder that will cut it.

A satisfactory method of cleaning terrazzo corridors is to get a cheap form of green soap which can be obtained from the manufacturer at three and one-half cents a pound. Dissolve ten quarts of this in a barrel of water, stirring it until the soap is dissolved; it will then remain in solution. Use this solution to mop with. The operator should have two pails, one containing the solution and another clean water; also a wringer and three mops, one for the solution, one for clear water, and a dry mop. The solution cleans readily but will leave a scum unless rinsed off and dried. Each cleaning generally means four operations—mopping once with the solution, mopping twice with clean water, and mopping once with a dry mop. This will leave the floor in splendid condition.

In private rooms it is better to use scrub brushes instead of mops. The solution described above may be followed up by some cleansing powder and the floor then thoroughly rinsed. Corridors should be mopped twice a day and private room floors daily.

DISH WASHING MACHINES AS STERILIZERS

To the Editor of THE MODERN HOSPITAL:

I notice in the columns of your magazine a statement regarding the sterilization of dishes used in serving typhoid patients. May I ask if some of the more modern dish washing machines do not sterilize the dishes sufficicently to remove the danger of contagion? I also notice that heavy earthenware is recommended. I have always been under the impression that vitrified china, because of its non-porous nature, was superior to earthenware and I understand vitrified ware will stand sterilization as well as earthenware.

READER.

There are no doubt on the market dish washing machines which, if used as directed, will sterilize dishes thoroughly, but the chief objection is that these infected dishes as they come from the patient are stacked up and sit around the kitchen; during this time they constitute a source of danger. The advantage of a utensil sterilizer is that dishes are put directly into it without being set on any table or other article of furniture. If the dishes were put into a dish washing machine directly as they come from the patient, a dish washer would meet all the requirements.

Your question about heavy earthenware is well taken. The word earthenware was used a little loosely; as a matter of fact most of the heavy ware used today is vitrified china. Vitrified china is very good because it stands up well both as to chipping and breakage.

RESPONSIBILITY FOR MEDICAL RECORDS

To the Editor of THE MODERN HOSPITAL:

Should not each doctor be responsible for the complete medical record of the patient and this record be left in the hospital?

A PHYSICIAN.

Yes, he should either keep it himself or see that it is done by someone else.

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Nurses Have Been Quick To See the Merit of the Arch Preserver Shoe—

ARCH PRESERVER SHOE
Don't wait for Foot Trouble -Prevent it!
ARCH PRESERVER SHOE
TRADE MARK REG. U.S. PAT. OFFICE
"KEEPS THE FOOT WELL"

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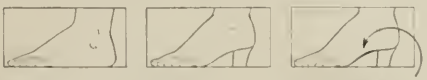
BECAUSE nurses know the value of working *with* Nature instead of against it in promoting health, they were quick to recognize the correctness of the Arch Preserver Shoe.

They realize that a shoe nears perfection just as it is able to offer the identical advantages of going "barefooted."

And they at once recognized all of the "barefoot" advantages in the Arch Preserver Shoe—with the added feature of style. They *must* have comfortable and healthy feet; they *want* to have well groomed feet. The Arch Preserver Shoe gives them both.



Nature plans that the foot rest on heel, ball and outside *arch*.

Civilization demands that heel and arch be *raised*.

The Arch Preserver Shoe satisfies *both* Nature and Civilization.

Made with an exclusive combination leather and rubber heel; leather at front to give stability, rubber at back to cushion shocks and prevent noise.

Write for Style Book No. 82 and name of dealer in your city or call the "Tell-U-Where" Information Bureaus. They will tell you where the Arch Preserver Shoe is sold.

THE SELBY SHOE COMPANY, 72 Gallia Street, Portsmouth, Ohio

FOREIGN CORRESPONDENCE

BRITISH PROVIDENT SCHEME FOR HOSPITAL AND MEDICAL SERVICES MEETS OPPOSITION

By Our London Correspondent

IN THE London letter of February the British National Provident Scheme for Hospital and Medical Services was discussed and the hope expressed that it might be for the benefit of all concerned.

Since that letter was written the scheme has been subjected to very severe criticism in *Health*, the journal of the Federation of Medical and Allied Societies by a well known London surgeon, Mr. Somerville Hastings. He is of the opinion that an insidious attempt is being made to change the character of the London hospitals which are founded for the necessitous poor and convert them into nursing homes for the middle classes. He holds that the Provident Scheme is a step and a long step in this direction. He moreover goes on to say that the scheme in Brighton where it was inaugurated proved a conspicuous failure and that if a similar scheme for London is to turn out a success it will only be because preferential treatment is given to its members.

Mr. Hastings points out that already there is a real shortage of hospital beds in London, and if, a large number of people who would never pass the almoners today, are to be added claimants for these beds with a preferential claim it will follow that those who are too poor to become members of the scheme, the necessitous poor for whom the hospitals were founded, will never get a look in at all and the sick will be driven back on the odious Poor Law from which the hospitals have been in the past their only escape. In short it is argued that if the Provident Scheme becomes general, people who can really afford to pay for medical treatment and nursing care will be the means of ousting a poor patient who could not possibly obtain such advantages in any other way. The writer of this critical article is rather in favor of patients paying as much as they can afford while in hospitals than that the Provident Scheme should be carried into effect on a large scale.

Criticism a Trifle Hasty

In the March number of *Health*, the honorary secretary of the Sussex Provident Scheme and Dr. J. F. Gordon Dill, the initiator of the scheme, warmly defend it. Of course, Mr. Hastings should have been more sure of his facts before he rushed into print, he is mistaken as to the maximum income limit for those who desire to participate in the benefits of the scheme and makes no practical suggestion as to how the income of the hospitals is to be permanently increased and the recurring annual deficit prevented. It has long been obvious that the middle classes of this country, or those with a limited income, are in a worse position so far as medical services and nursing are concerned than any group in the community. The poor have access to the hospitals and the rich can afford to enter expensive nursing homes, but the individual with a limited income can do neither and has to be content with the services of the ordinary medical practitioner, with unskilled home nursing and with the unhygienic conditions of the usual middle class home. There is no doubt that the lot of the person with limited income who meets with an accident or is sick is hard and should be alleviated, but whether the Provident Scheme will adequately and fairly overcome the difficulties has yet to be proved. It certainly savours of charity, as a great deal appears to be given or promised for a small outlay.

Would it not be better to introduce the pay system into the British hospitals, that is, each one to pay for treatment and care according to his or her means, provided always that sufficient room is found for the truly indigent. The members of approved societies can scarcely be classed as necessitous poor, and as a matter of fact, these societies are beginning to recognize their responsibilities and duties towards the hospitals and are contributing considerable amounts in return for services rendered to their members. The workmen of large industrial concerns in many parts of the country contribute a weekly sum per head to defray or to help defray the expenses of those who may require hospital medical attention and care. The plan is likely to be general throughout the country. Therefore the really indigent after all do not constitute a large proportion of the population and should be easily dealt with either as in- or out-patients of the hospitals. If paying wards were made a part of the hospital system, those with limited incomes would be able to command as skilful medical and surgical attendance and as careful nursing as hitherto has only been open to the rich and poor. When the number of beds in British hospitals is considered it is patent that a very large number of people must have received and are receiving hospital nursing treatment for nothing who were and are able to pay something; some of them able to pay well for such services. It is clear that the hospitals have been abused, in some instances

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It is not a question whether a hospital can afford The Johnson Pneumatic System of Temperature Regulation. The question is can any hospital afford to be without The Johnson. There are so many serious elements in conducting a hospital which must receive Johnson Service to attain utmost efficiency, that the Johnson System should be taken for granted: on equal basis with the hospital's equipment for surgery and medicine.

JOHNSON SERVICE COMPANY, MILWAUKEE

grossly abused. By patients paying what they can afford, not only would the hospitals be placed on a sound financial basis but patients would retain their independence and self respect, and that large and deserving part of the community, those with limited incomes, would be able to enjoy the privileges of proper medical treatment and nursing which have been denied them up to the present time.

Societies Should Contribute to Hospitals

Undoubtedly there are other sides to the question. The character of the hospitals would be greatly altered. However, these institutions are in such desperate straits that only desperate remedies will avail. Showing which way the wind is blowing is a scheme of home nursing which has just been provided by the approved societies. It has been stated recently by an authority that if an approved society has funds on which it can draw to provide its members with the skilled service of the district nurse, it is false economy to abstain from doing so. The members of approved societies are beginning to realize this fact. The approved societies have a disposable surplus of £9,000,000 ($45,000,000), largely due to war casualties, which has so improved their financial position that it brought them to a sense of this realization. Many of these societies now provide home nursing and it seems more than likely that in the not far distant future they will all contribute to the hospitals, recognizing that in grave diseases and serious accidents the hospital is the one place in which skilled medical service and careful nursing can be obtained, and that it would be a calamity for the entire community, including the members of the approved societies, if the hospitals were allowed to close their doors or to lapse from their high standard. Indeed hospitals are more greatly needed than ever before and as time goes on will be more and more in request.

The Provident Scheme in any event will not go far in solving the hospital problem and should be analyzed closely before it is adopted on a wide scale. The best that can be said of it is that it is on trial.

THE PERSONALITY OF A HOSPITAL

The Massachusetts General Hospital is 100 years old, a tender age considering the generations man has inhabited the region about Boston. The Indians of Massachusetts had sickness in their tribes, but no hospitals; their predecessors, whoever they were, had disease, but no hospitals. It required a stable government and high-minded men with an insatiable desire for service to their fellow men, before the old Bulfinch building could rise above the sick of Boston. Warren and Jackson, founders of the Massachusetts General Hospital, were such men. Their ideals of service and their devotion gave an impetus to the new organization that carried it honorably through one century. The Bigelow, Shattucks, Cabots, Cushing and others have kept those ideals living, and have seen them grow until rooted in every department of the much larger and older organization. The development of the personality of Massachusetts General is an interesting story, as told by Dr. Harvey Cushing in his "Ether Day" address on the seventy-fifth anniversary of that great discovery. "Like an old wine," he said, "it has acquired a certain quality which only comes with age, and a new institution cannot imitate, for it represents the fusion of the countless personalities of all those who have worked for it or in it, no matter how lowly. * * * Anesthesia christened by Holmes, litholapaxy by Bigelow, appendicitis by Fitz, are three unquestioned offspring of the Massachusetts General Hospital." Credit is given to the humbler servants as well as to those medical men whose work helped to make the institution so well known: the faithful Hugh McGee, who served for fifty years, and James Mains, with his parkinsonian tremor, who was the mainstay of the Bigelow amphitheater for nearly as long. Then there was Barry, inimitable mimic of surgeons who had gone before, Pipper the night orderly, "Outpatient" John, and Louis Brown, who first came a boy with osteomyelitis, and died in the hospital thirty days later from complications of his old malady, meanwhile having become, a photomicrographic expert, a most useful and loyal servant of the hospital. Distinguished organizations devoted to the sick are too few in number. Age is not absolutely necessary, but character, skill and cooperation are indispensable.—*Jour. A. M. A.*, April 8, 1922.

BOOKS RECEIVED

MATERIA MEDICA, PHARMACOLOGY AND THERAPEUTICS FOR NURSES. Outlines of Internal Medicine for the Use of Nurses and Junior Medical Students. By Clifford Bailey Farr, A.M., M.D., Professor of Gastro-Enterology, Graduate School of Medicine and Associate in Medical Department University of Pennsylvania. Third and revised edition. Lea and Ferbiger, Philadelphia and New York, 1920.

APPLIED PSYCHOLOGY FOR NURSES. A Textbook of Simple Nursing Procedure for Use in High Schools, together with instruction for first aid in emergencies. By Amy E. Pope, formerly instructor in the School of Nursing, Presbyterian Hospital, New York. G. P. Putnam's Sons, New York and London, 1921.

TYPHUS FEVER WITH PARTICULAR REFERENCE TO THE SERBIAN EPIDEMIC. By Richard P. Strong, M.D., S.D., Director of the American Red Cross and International Sanitary Commission to Serbia, Professor of Tropical Medicine, Harvard University Medical School; George C. Shattuck, A.M., M.D., Member of the Red Cross Sanitary Commission to Serbia, General Medical Secretary, League of Red Cross Societies; Hans Zinsser, M.D., Bacteriologist of the American Red Cross Sanitary Commission to Serbia, Professor of Bacteriology, Columbia University; A. W. Sellards, A.M., M.D., Member of the American Red Cross Sanitary Commission to Serbia, Assistant Professor of Tropical Medicine, Harvard University Medical School; J. Gardner Hopkins, M.D., Bacteriologist of the American Red Cross Sanitary Commission to Serbia. Published by the American Red Cross at the Harvard University Press, Cambridge, Mass., 1920.

A MANUAL OF SELECTED BIOCHEMICAL METHODS, as Applied to Urine, Blood and Gastric Analysis. By Frank P. Underhill, Ph.D., Professor of Pharmacology and Toxicology, School of Medicine, Yale University. New York, John Wiley & Sons, Inc.; London, Chapman & Hall, Ltd., 1921.

THE PLACE OF VERSION IN OBSTETRICS. By Irving W. Potter, M.D., F.A.C.S., Buffalo, New York; Obstetrician in Chief, Deaconess Hospital and St. Mary's Maternity Hospital; Attending Obstetrician, City Hospital; Consulting Obstetrician, Columbus Hospital, Buffalo Homeopathic Hospital and Salvation Army Home. With forty-two illustrations. C. V. Mosby Company, St. Louis, 1922.

GLANDS IN HEALTH AND DISEASE. By Benjamin Harrow, Ph.D., Associate in Physiological Chemistry, College of Physicians and Surgeons, Columbia University. E. P. Dutton & Company, New York, 1922.

A MANUAL OF OBSTETRICAL NURSING. By Nancy E. Cadmus, R.N., General Director of the Maternity Center Association, Former Superintendent of Manhattan Maternity Dispensary, Former Member of New York State Board of Nurse Examiners, Former President of New York State League of Nursing Education. G. P. Putnam's Sons, New York, 1922.

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XIX *August 1922* No. 2

COMMITTEE ON NURSING EDUCATION ISSUES NOTABLE REPORT

THE committee which presents the following report was first appointed by the Rockefeller Foundation in January, 1919, to conduct a study of "the proper training of public health nurses."

It was, therefore, the pressing need for more, and for better, nurses in the field of public health that first suggested the desirability of such an investigation. It soon became clear, however, that the entire problem of nursing and of nursing education, relating to the care of the sick as well as to the prevention of disease, formed one essential whole and must be so considered if sound conclusions were to be attained. A year later, in February, 1920, the Foundation requested us to broaden the scope of our inquiry to include "a study of general nursing education, with a view to developing a program for further study and for recommendation of further procedure." We have attempted, therefore, to survey the entire field occupied by the nurse and other workers of related type; to form a conception of the tasks to be performed and the qualifications necessary for their execution; and on the basis of such a study of function to establish sound minimum educational standards for each type of nursing service for which there appears to be a vital social need.

Members of the committee are: C.-E. A. Winslow, chairman, Mary Beard, Herman M. Biggs, L. Lillian Clayton, Lewis A. Connor, David L. Edsall, Livingston Farrand, Annie W. Goodrich, L. Emmett Holt, Julia C. Lathrop, Isabel W. Lowman, M. Adelaide Nutting, Christopher G. Parnall, Thomas W. Salmon, Winfred H. Smith, E. G. Stillman, Lillian D. Wald, William H. Welch and Helen Wood. Miss Josephine Goldmark was secretary of the committee.

Since it was the obvious need for more adequate nursing service in the field of public health which brought to a head the demand for a comprehensive study of nursing education, long-felt and first voiced by the official organization of nurses, it seems natural to begin with a consideration of this phase of the broader problem.

It is obvious that the public health movement has passed far beyond its earlier objectives of community sanitation and the control of the contact-borne diseases by isolation and the use of sera and vaccines. Major health problems of the present day, such as the control of infant mortality and tuberculosis, can be solved only through personal hygiene—an alteration in the daily habits of the individual—and through the establishment of new contacts with the public—contacts which shall permit the application of the resources of medical science at a stage in disease when they can produce a maximum effect. Such changes in the daily habits of the people and in their relation to their medical advisors, can be accomplished by but one means—education. In its present phase of emphasis on personal hygiene, the public health movement has thus become during the past two decades preeminently a campaign of popular education.

The new educational objectives of the health administrator may be approached to a limited extent by mass methods. The printed page, the public lecture, the exhibit, the cinematograph, the radiogram, help to prepare the ground and to make success easier. The ultimate victory over ignorance is, however, rarely attained in such ways. Direct personal contact with the conditions of the individual life is essential to success in a matter so truly personal as hygiene. We have sought during the past twenty years for a missionary to carry the message of health into each individual home; and in America we have found this messenger of health in the public health nurse. In order to meet generally accepted standards we should have approximately 50,000 public health nurses to serve the population of the United States—as against 11,000 now in the field. All public health authorities will probably agree that the need for nurses is the largest outstanding problem before the health administrator of the present day.

In view of this fact, public health authorities, both in this country and abroad, have naturally considered the

possibility of finding a short way out of their difficulties by the employment of women trained in some less rigorous fashion than that involved in the education of the nurse. It was, therefore, to the question of the necessary and desirable equipment of the teacher of hygiene in the home that we first directed our attention. There are at present two distinct types of public health nursing practice in the United States—that in which the nurse confines herself to the teaching of hygiene, and that in which such instructive work is combined with the actual care of the sick. A third type of visiting nursing, in which bedside care is given with no educational service, may be observed in individual instances. It results, however, from temporary limitations rather than considered policy, since practically all visiting nurse associations, in theory at least, stress hygienic education in their official program.

The question whether the public health nurse should or should not also render bedside care has been hotly debated during the past few years. The arguments for purely instructive service rest mainly on two grounds, the administrative difficulties involved in the conduct of private sick nursing by official health agencies and the danger that the urgent demands of sick nursing may lead to the neglect of preventive educational measures which are of more basic and fundamental significance. Both of these objections are real and important ones. Yet the observations made in the course of our survey indicate that both may perhaps ultimately be overcome.

Several municipal health departments have definitely undertaken to provide organized nursing service for bedside care combined with health teaching, while in other instances instructive nurses, under public auspices, combine a certain amount of emergency service with their fundamentally educational activities. So far as the neglect of instructive work is concerned it results from numerical inadequacy of personnel and can be avoided by a sufficiently large nursing staff.

On the other hand the plan of instructive nursing divorced from bedside care suffers from defects which if less obvious than those mentioned above are in reality more serious, because they are inherent in the very plan itself and therefore not subject to control. In the first place the introduction of the instructive but non-nursing field worker creates at once a duplication of effort, since there must be a nurse from some other agency employed in the same district to give bedside care. In the second place the field worker who attempts health education without giving nursing care is by that very fact cut off from the contact which gives the instructive bedside nurse her most important psychological asset. The nurse who approaches a family where sickness exists and renders direct technical service in mitigating the burden of that sickness, has an overwhelming advantage, then and thereafter, in teaching the lessons of hygiene. With an adequate number of nurses per unit of population, we believe that the combined service of teaching and nursing will yield the largest results.

Nurses employed by state health departments and others whose work is largely stimulative and supervisory in nature may not, of course, be in position to render direct bedside care.

There are other messengers who may be sent into the field to fulfill other functions. The task of the trained social worker for example is to diagnosticate and repair maladjustments in social relationships, a correlated but quite distinct vocational field. Even public health agencies may employ other field workers of an allied type, such as clinic messengers. It is obvious, however, that where health instruction is combined with bedside care the fully trained nurse is the only possible type of health educator; and such a combination represents the one type of service which it is feasible to supply in rural districts. Even purely instructive work, if conducted on the generalized district plan, calls for an ability to detect the early signs of contagious disease, to discern symptoms which suggest tuberculosis, to give counsel as to infant care or the feeding of older children, which can scarcely be attained without a wide training. The relative lack of nursing personnel in Europe has there led to the attempt to train health visitors of the purely instructive type for dealing with special individual problems, such as tuberculosis or child welfare, by training courses much shorter than those required for the preparation of the nurse. Opinion as to the result of such experiments in Europe varies widely; but for conditions as they exist in the United States we are convinced that the teacher of hygiene in the home should be equipped with no less rigorous training than that accorded to the bedside nurse, further supplemented by special studies along the lines of public health and social service.

Qualifications of Public Health Nurse

That an improvement in quality, as well as an increase in the number of public health nurses, is fundamental to the complete success of the public health movement is a point on which we find all competent authorities to be substantially agreed.

Miss Goldmark's report of an intensive study of the daily work of 164 public health nurses, representing 47 different organizations, gives glimpses of women whose constructive service and compelling personal inspiration seem to touch the highest possibilities of social achievement. Such a nurse establishes herself in the confidence of her community, so that she becomes its trusted advisor and best friend, caring for the sick, securing medical aid, counselling as to hygiene, resolving difficulties of a hundred sorts with the touch of a practised band.

Nearly half of the nurses observed in our survey were classed as definitely successful in their work and less than one-fourth as definitely unsuccessful—a showing perhaps better than would be made by a random sampling of most professions. Yet it remains true that either from a lack of knowledge of preventive measures or of teaching methods, from failure to effect contact with physicians or with social agencies, a substantial proportion of public health nurses do fail to realize the possibilities of their profession. Administrative policies, overloading and inadequate supervision are sometimes at the root of the trouble; yet it is obvious that such a calling as public health nursing demands in the first place a high degree of natural capacity and in the second place a sound and a broad education.

We are convinced, therefore, that the teacher of hygiene in the home should possess in the first place the fundamental education of the nurse and that this should be supplemented by a graduate course in the special problems of public health. The latter point will be discussed in detail in a succeeding paragraph but we believe that the general considerations so far discussed warrant the following conclusion:

Conclusion 1. That, since constructive health work and health teaching in families is best done by persons:

(a) Capable of giving general health instruction, as distinguished from instruction in any one specialty; and

(b) capable of rendering bedside care at need,

the agent responsible for such constructive health work and health teaching in families should have completed the nurses' training. There will, of course, be need for the employment, in addition to the public health nurse, of other types of experts such as nutrition workers, occupational therapists, and the like.

That as soon as may be practicable all agencies, public or private, employing public health nurses, should require as a pre-requisite for employment the basic hospital training, followed by a post-graduate course, including both class work and field work, in public health nursing.

Need of High Grade Nurses

Before considering the basic demand for nurses to function in the routine care of the sick we must point out that it is by no means only in the field of public health nursing, that the need for women of high natural qualifications and fundamental training is now manifest. The modern hospital and the modern dispensary represent social forces of enormous and growing magnitude. The technical complexity of their operation increases with every passing year; and, aside from the problem of the staff nurses required for the ordinary routine of such institutions, which will be discussed in a succeeding paragraph, there is perhaps no more urgent problem for the hospital administrator than that of obtaining nursing superintendents and supervisors adequate for the performance of their difficult tasks. The development, both of public health nursing and of administrative hospital nursing, involves and demands a corresponding development in nursing education which constitutes another inviting field for women.

The defective preparation and qualifications of many instructors in schools of nursing, in both theoretical and practical branches, is very marked. Yet in the training school the instructor is often called upon to teach six or eight different subjects, far more than would be demanded even of the teacher in a country high school. It should be noted, however, that the appointment of any full-time instructors is a very recent development and has marked a signal educational advance.

With the development of nursing education which we visualize in the future, and particularly with the growth of university schools of

nursing, to be discussed in a succeeding paragraph, the field for well-qualified teachers of nursing should prove an increasingly attractive one. We believe we may safely advance as

Conclusion 2. That the career open to young women of high capacity in public health nursing or in hospital supervision and nursing education, is one of the most attractive fields now open in its promise of professional success and of rewarding public service; and that every effort should be made to attract such women into this field.

The Problem of Nursing the Sick

We may pass next to the urgent and fundamental problem of providing nursing care for the sick of the community. Here we find far less unanimity of sentiment, in regard either to the quantitative or the qualitative adequacy of nursing service under existing conditions. An appalling shortage of nurses existed during the war; but conditions have materially changed during the past three years. The census reports show an increase in trained registered nurses, male and female, from 82,327 in 1910 to 149,128 in 1920, a truly phenomenal increase of 83 per cent. Some 11,000 of these are employed as public health nurses and approximately the same number in hospitals, and other institutions, leaving over 120,000 for private duty service, of whom, however, many are in the active practice of their profession. This 1920 figure gives us a ratio of one trained nurse to 700 persons for the country as a whole. The majority of trained nurses are concentrated in the larger cities so that the rural districts in many states are wholly lacking in service of this kind. The evidence is that, at present in the cities, the supply of trained nurses is adequate to existing demands in normal times. The reason why many persons who need nursing care in hospitals and in the homes of the poor fail to receive it is to be sought in economic factors, rather than in a shortage of nurses.

Dr. C.-E. A. Winslow, Chairman of the Committee on Nursing Education of the Rockefeller Foundation.

In regard to the quality of the nursing service available at the present day we find more radical differences of opinion. Private physicians frequently express the view that for ordinary nursing, even the graduate of the existing training school is "overtrained," that the service which she renders is too costly, and that a woman with a very brief training in bedside routine would be as satisfactory, or perhaps more satisfactory, than the average registered nurse. As a result of this feeling there have been persistent and vigorous efforts in certain quarters to break down the standards of nursing education which have been laboriously built up during the past twenty years.

Insofar as these efforts would remove the safeguards which guarantee to the patient suffering from acute disease, and to the physician caring for such a patient, the quality of service necessary for safety, we feel that they constitute a real danger to the cause of public health. Nurses, physicians, hospital authorities and legislators, in erecting these safeguards, have been inspired by a just sense of the vital dangers to life which may result from the unskilled nursing of a critical case and of the grave responsibility incurred by both the medical and the nursing professions when such malpractise occurs. We would therefore record our conviction in regard to this point as:

Conclusion 3. That for the care of persons suffering from serious and acute disease the safety of the patient, and the responsibility of the medical and nursing professions, demand the maintenance of the standards of educational attainment now generally accepted by the best sentiment of both professions and embodied in the legislation of the more progressive states; and that any attempt to lower these standards would be fraught with real danger to the public.

The Subsidiary Type of Nursing

When we find that certain private physicians, like the public health administrators, demand nurses of a higher quality than those now in the field, while others desire merely "hands for the physician" with a minimum of education below the present standard, it seems probable that there is reason on both sides and that the apparent conflict is due to a difference in the objectives to be met. For the care of acute and serious illness and for public health work it seems certain that we need high natural qualifications and sound technical education; for the care of mild and chronic illness and convalescence it may well be that a different type of capacity and training may be necessary.

It seems clear to the committee, however, that if two types of nursing service are desirable the distinction should be drawn not on economic grounds but according to the type of illness involved.

We are even somewhat doubtful as to the possibility of attaining very substantial economies by the introduction of a subsidiary type of private duty nurse. Our survey of the situation does not indicate that the income of the private duty nurse is at present generally an exorbitant one, when we take into account the amount of unemployment—amounting in a typical group of 118 nurses to a week each month during the busy winter season. If this factor be allowed for, the margin between the average annual income of the private duty nurse and that of the domestic servant is not so great as to permit of the existence of an intermediate grade on a salary level very much below that of the present registered nurse.

The solution of the economic problem which confronts the family of low income must probably be sought along the lines of cost distribution through some form of community organization, or along the lines of group insurance such as that being experimentally tested in New York City.

In any event, a pneumonia case, a diphtheria case, a grave cardiac case will require the highest grade of nursing obtainable, whether it occurs in a palace or a hovel. It is the mild and chronic and convalescent case which offers a field for the partially trained worker, and the exact extent of this field has never yet been fully surveyed. In our own study we have secured careful esti-

mates from 118 graduate nurses which indicate that during a period of three months, one quarter of their time was spent on cases which could have been cared for by an attendant of the partially trained type. A somewhat similar estimate was obtained from 48 practicing physicians, 21 believing that trained nurses were unnecessarily employed for less than a quarter of their cases, 17 placing the figure between half and three-quarters and 10 at over three-quarters.

In considering the problem of subsidiary nursing service it must be remembered that we are dealing with no new development. Of the 300,000 male and female nurses in the United States in 1920, slightly more than half were of grades below the standard of the graduate nurse. The "practical nurse," the "trained attendant," is an existing fact, and in the opinion of a large group of the medical profession who utilize her services she fills a real place in the complex problem of caring for the sick.

If we include with the trained and registered nurses (149,128) the student nurses in hospitals (54,953) and to these add the number of attendants and practical nurses (151,996), as constituting the entire body of persons occupied in caring for the sick we have altogether one nurse, trained or untrained, to every 294 well persons. This would seem to give an adequate supply if numbers alone are considered, provided a proper distribution could be secured.

On the other hand the dangers in the existence of loosely defined and unregulated group of partially trained workers in the same field as a more highly educated type constitutes a real and a serious complication. The nursing profession has discharged a fundamental duty to the public in stimulating the development of registration laws which define and delimit the practice of that profession, and protect the community against fraud and exploitation by those who collect fees and assume responsibilities to which their qualifications do not entitle them. In addition to the registration of the trained nurse it is essential that the lower grade of nursing service should also be defined and registered; and the states of New York, Missouri, California, Michigan, and Maryland have taken definite steps in enacting legislation toward this end. The name to be selected for the subsidiary group is a different problem. As is so often the case the root of disagreement lies largely in nomenclature. The title "attendant" embodies in four of the laws mentioned above is distasteful to those who bear it and tends to discourage the enlistment of those who may desire to enter this field. On the other hand the term "practical nurse" assumes a most unfortunate antithesis between education and practice; and the splendid professional and public service rendered by "the nurse" in war and in peace entitles her to the protection of her existing professional status. We are inclined to believe that the term "nursing aide" or "nursing attendant" best meets the need for clear differentiation, while providing the subsidiary worker with a suitable name.

With two distinct grades of service available, the individual physician would be responsible for the choice of a trained nurse or a nursing attendant or nursing aide in a given instance. The public can only be safeguarded in these matters by state legislation providing for licensing of nursing registries and requiring explicit statements as to the license qualifications of each nurse or nursing aide furnished. We believe that by this means the maximum increase of nursing service possible under existing economic conditions could be attained; and we would therefore recommend as

Conclusion 4. That steps should be taken through state legislation for the definition and licensure of a subsidiary grade of nursing service, the subsidiary type of worker to serve under practicing physicians in the care of mild and chronic illness, and convalescence, and possibly to assist under the direction of the trained nurse in certain phases of hospital and visiting nursing.

Our survey of the actual field of nursing service has thus led us to the conclusion that the good of the community demands (a) the recruiting for public health nursing, hospital training, and the care of the acutely ill of a larger number of young women of good natural capacity and the provision for such women of a sound and effective education; and (b) the development and standardization of a subsidiary nursing service of a different grade for the care of mild and chronic disease. We may next pass to the second part of our problem—a consideration of existing educational facilities for the training of the two types of workers indicated as desirable.

So far as the trained nurse is concerned, whether she is to function in private duty, in public health or in institutional service, it is clear that her basic professional education must be acquired in the hospital training school. We have, therefore, devoted a major part of the present investigation to a somewhat detailed study of existing conditions and future possibilities in hospital training.

The development of the hospital training school for nurses constitutes a unique chapter in the history of education. In almost all fields of professional life, education has begun on a basis of apprentice training. The first law schools and the first medical schools were the outgrowth of the lawyer's and the physician's office. In nearly all other fields than that of nursing, however, even in such relatively new professions as journalism and business and advertising, education has outgrown the apprentice stage and leadership has passed into the hands of independent institutions, organized and endowed for a specifically educational purpose. The training of nurses, on a basis of apprentice training, actually if not technically directed by organizations created and maintained for the care of disease rather than for professional education.

The progress which has been accomplished in nursing education under such anomalous conditions is such as to reflect high credit upon both hospital administrators and the leaders of the nursing profession. The hospitals have in many instances been inspired by a broad and constructive vision of training school possibilities; while the devotion with which nursing directors have labored for high standards, often against almost insuperable obstacles, calls for the warmest admiration. Yet the conflict of interests between a policy of hospital administration which properly aims to care for the sick at a minimum cost and a policy of nursing education which with equal propriety aims to concentrate a maximum of rewarding training into a minimum time is a real and vital one.

The fact that a field so tempting as that of modern nursing, with its remarkable possibilities of service in public health, in institutional management and in teaching fails to attract students in the number and of the quality we should desire strongly suggests that there is some shortcoming in the established avenues of approach to the nursing profession. The hospitals themselves, depending as they do so largely upon student nurses for their routine operation, have in past years found themselves seriously handicapped by the small number of applicants, and many a superintendent will testify to the fact that the difficulty of securing a high quality of nursing is one of the gravest which he has to meet. The phenomenally rapid growth in the number of hospitals has created within a brief period a demand for a large number of students and the requirements for admission have therefore been kept at a very low level, thus resulting in a reduction in the proportion of well-educated applicants. For the good of the hospital, as well as for that of the nursing profession and of the public at large, a careful and dispassionate appraisal of the adequacy of the present day training school would seem to be urgently desirable.

Conditions in Typical Training Schools

An extensive survey of the vast field of hospital training schools (there are over 1,800 such schools in the United States) was obviously beyond the possible resources of our committee. It was therefore decided to select a small group of schools, of reasonably typical character, for intensive study. Twenty-three such schools were finally chosen, representing large and small, public and private, general and special hospitals, in various sections of the United States. These schools were undoubtedly well above the median grade and their average may, we believe, be taken as fairly representative of the best current practice in nursing education. Each school was studied in detail by two types of investigators, one a practical expert in nursing education and the other an experienced educator from outside the nursing field. By this means we aimed, on the one hand to secure competent criticism of nursing procedures, and on the other a broad viewpoint of general educational standards. The detailed results of this investigation as presented in Miss Goldmark's report, will, we believe, prove highly enlightening to the student of this problem.

The training of the nurse involves a certain basic knowledge of the fundamental chemical and biological sciences, theoretical instruction in the principles of nurs-

ing, and, above all, supervised practical training in actual nursing procedures. In all three phases of this work Miss Goldmark's report reveals conspicuous successes and equally conspicuous failures; and the remarkable thing is that successes and failures so often appear side by side in the same institution.

Thus, we may find in a training school with a good ward service that the fundamental science courses fail because of wholly inadequate laboratory equipment. In another school, the theoretical instructor may show a hopeless lack of teaching ability (as in the case of class presentation which consisted in the dictation of questions and answers from a prehistoric notebook); or she may be so handicapped by other duties as to leave no time for the proper conduct of her classes. Lectures by physicians may be informative and inspiring in one department of a hospital, irregular in delivery, careless and dull in content in another. Ward assignments are in many cases largely dictated by the need for hospital service rather than by the educational requirements of the students. This is clearly evidenced by the astonishing irregularity of the time spent on different services by individual students and by the marked deviation between all the time assignments actually performed and those scheduled in the official program of the course. Thus in one school where seven and one-half months was assigned to surgical service the members of a single class had actually worked on this service for from seven to thirteen and three-quarters months. Of the 23 schools surveyed by us one made no adequate provision for obstetrical service, while five gave no training in pediatrics, seven no experience in communicable disease and eighteen none in mental disease. A review of the difficulties in making affiliations in some of these subjects, notably in communicable and mental diseases, some of these omissions are scarcely to be wondered at.

The supervision of work on the wards was in certain instances notably inadequate. In only a few brilliantly exceptional cases was the ward work purposefully correlated with theoretical instruction. The lack of an intelligently planned progressive training was obvious in a large number of the hospitals studied, first year students often being found in positions of responsibility for which they were unprepared, while seniors in another ward were repeating an educationally idle and profitless routine. Most striking of all, was the factor of time wasted in procedures, essential to the conduct of the hospital, but of no education value to the student concerned. Hours and days spent in performing the work of a ward maid, in putting away linen, in sterilizing apparatus, in mending rubber gloves, in running errands, nursing at present technique involved had become second nature, accounted in one typical hospital where this problem was specially studied for a clear wastage of between one-fourth and one-fifth of the student's working day.

The total amount of time assigned to ward service under the conditions which obtain in many hospitals is, in itself, a fairly complete obstacle to educational achievement. Our selected group of hospitals, surely in this respect above the general average, shows a median day of 8.5 hours on ward duty alone, exclusive of all classroom instruction. Irregular and excessive and unproductive night duty is the rule rather than the exception. Crowded and unattractive living conditions tend, in certain hospitals, to impair the morale of the student body and an atmosphere of autocratic discipline frequently prevents the development of a psychological atmosphere favorable to effective cooperative work.

The foregoing paragraphs present, we are aware, a somewhat gloomy picture. In presenting them, we would emphasize two points which are of major importance. In the first place, such shortcomings as have been pointed out are not fairly chargeable to deliberate neglect on the part of hospital authorities or nursing superintendents, insofar as they exist, they are due to the inherent difficulty of adjusting the conflicting claims of hospital management and nursing education under a system in which nursing education is provided with no independent financial endowment foe its specific ends. The difficulties involved in the task of resolving this conflict are perhaps illustrated by the fact that out of 144 registered training schools in New York state, 60 changed superintendents during a single recent year.

In the second place it is encouraging to note, by reference to Miss Goldmark's report, that every one of the shortcomings in hospital training discussed above has been substantially complete success, in one or more of the training schools studied by our investigators. The difficulties are not insuperable. Each of them has been overcome in some schools and most of them in some of the best schools. Training schools exist today in which the student receives a sound and an inspiring education, with a minimum of sacrifice to the exigencies of hospital administration. Yet such schools are still the exception; and we are convinced that the progress we desire can come only through a frank facing of the truth. The following statement is, we believe, thoroughly justified by such facts as we have been able to obtain:

Conclusion 5. That, while training schools for nurses have made remarkable progress, and while the best schools of today in many respects reach a high level of educational attainment, the average hospital training school is not organized on such a basis as to conform to the standards accepted in other educational fields; that the instruction in such schools is frequently casual and uncorrelated; that the educational needs and the health and strength of students are frequently sacrificed to practical hospital exigencies; that such shortcomings are primarily due to the lack of independent endowments for nursing education; that existing educational facilities are on the whole in the majority of schools inadequate for the preparation of the high grade of nurses required for the care of serious illness and for service in the fields of public health nursing and nursing education, and that one of the chief reasons for the lack of sufficient recruits of a high type to meet such needs lies precisely in the fact that the average hospital training school does not offer a sufficiently attractive avenue of entrance to this field.

Improving the Hospital Training School

Miss Goldmark's study has not stopped short with a revelation of the defects which are commonly found in the conduct of nursing education. It makes clear that only the coordination and standardization of the best existing practice is necessary in order to place nursing education on the plane where it belongs.

In the first place we believe that a training school which aims to educate nurses capable of caring for acute disease or of going on into public health nursing or supervisory and teaching positions must require for entrance the completion of a high school course or its equivalent. Nearly one-third of all the training schools in the United States now make this requirement, and with 150,000 girls graduating from high schools every year it should be possible for well-organized courses to attract an ample number of candidates.

The course should begin with a preliminary term of four months' training in the basic sciences and in elementary nursing procedures with appropriate ward practice but without regular service, as outlined in Miss Goldmark's report. The necessary teaching personnel and laboratory equipment for the former may in many instances be secured by the smaller hospitals through the establishment of a central training course or by cooperation with high schools, normal schools or junior colleges.

There should then follow a period of twenty-four months (including two months for vacation) devoted to a carefully graded and progressive course in the theory and practice of nursing, with lectures and ward practice so correlated as to facilitate intelligent case study and with the elimination of routine duties of no educational value. Hospital and dispensary services in medicine, surgery, pediatrics, obstetrics, communicable diseases and mental diseases should be provided through appropriate affiliation. Teachers and equipment should be of such a grade as would be acceptable in a reputable college or normal school.

We regard it as fundamental that the working day foe the student nurse, including ward work and classroom periods, should not exceed eight hours. The working week should not exceed 48 hours and preferably 44 hours. Training school experience, as well as a comparison with that accumulated in other educational fields, makes it clear that a longer period of scheduled work for the student is incompatible, either with educational attainment or with the maintenance of health.

By such an organization of the course of study, and particularly by the elimination of unrewarding routine service, we are convinced that the period of training may be safely shortened from the present standard of three years to twenty eight months. Such a saving would mean an increase of over 20 per cent in the potential output of the training school through the saving of time alone. The shortening of the course would, in itself, prove an attraction to the prospective student; but the main consideration to be kept in view is that the shorter course projected would not imply a lowering but a raising of educational standards. Miss Goldmark's study of the situation makes it clear that the intensively planned course of twenty-eight months would involve no substantial sacrifice in a single service as compared with the actual median practice of the present day and would supply other services now almost universally neglected. It is the experience in every other field of education that the way to attract students is to raise standards, not to lower them. In medicine, in law, in engineering, in teaching, the schools which raise requirements are the ones from which students must be turned away; and even in nursing the success of the better schools furnished convincing testimony to the same basic principle. It is the higher standing of the course here outlined, quite as much as its lessened length, which we are confident would insure an increase in the number of students, as well as an improvement in their quality.

There are, we believe, two fundamental essentials to the success of a training school planned on the suggested lines. It must first of all be directed by a board or a committee, organized more or less independently for the primary purposes of education. The interests of hospital management and of educational policy must necessarily at times conflict and unless the educational viewpoint is competently represented the training school will infallibly suffer in the end. In the second place it is fundamental to the success of nursing education that adequate funds should be available for the educational expenses of the school itself, and for the replacement of student nurses by graduate nurses and hospital help in the execution of routine duties of a non educational character. A satisfactory relationship between school and hospital demands careful cost-accounting and a clear analysis of the money value of services rendered by the school to the pupil and the hospital, by the pupil to the hospital, and by the hospital to the pupil and the school. The cost of adequate education must in any case be a paramount consideration, to which we shall return in a succeeding paragraph. Assuming its essential importance, the following conclusion seems to us justified:

Conclusion 6. That, with the necessary financial support, and under a separate board or training school committee organized primarily for educational purposes, it is possible, with completion of a high school course or its equivalent as a prerequisite, to reduce the fundamental period of hospital training to 28 months and at the same time, by eliminating unessential, non-educational routine, and adopting the principles laid down in Miss Goldmark's

report to organize the course along intensive and coordinated lines with such modifications as may be necessary for practical application; and that courses of this standard would be reasonably certain to attract students of high quality in increasing numbers.

Post-Graduate Nursing Education

The course of twenty-eight months discussed above would furnish the complete education for a student desiring to practice as a bedside nurse in private duty or in hospitals and other institutions; and its completion should entitle her to the diploma in nursing and to state registration. For the nurse who desires to specialize along either of the more advanced lines of public health nursing, or hospital supervision and nursing education, a further period of post-graduate training is obviously desirable.

Teachers College in Columbia University has played the part of pioneer in preparing graduate nurses for hospital supervision and nursing education; and certain of the newer university schools of nursing are already offering attractive courses along the same line. The development of graduate courses in public health nursing has made even more notable progress. The first organized course of this type was offered in Boston in 1906 and by 1920 there were twenty such courses in operation, under the auspices of universities, public health nursing associations or schools of social work.

The activities of sixteen of these schools of public health nursing have been studied in the course of our investigation and the results achieved in this new field are in general deserving of high praise. The course is apparently in process of standardization at a length of about eight months, four devoted to theoretical instruction in public health, public health nursing, educational psychology and social problems, and four to supervised field work with a public health nursing organization. The courses at present offered are in many instances tentative and lacking in assured financial status. With the development of the university school of nursing (to be discussed in succeeding paragraphs) they may be expected to fall within its sphere of influence and to develop an increasing stability and usefulness.

Conclusion 7. Superintendents, supervisors, instructors and public health nurses should in all cases receive special additional training beyond the basic nursing course.

The University School of Nursing

For advanced training the development of the university school of nursing has been perhaps the most notable feature in the progress of nursing education during the past ten years. As long ago as 1899 Teachers College in Columbia University admitted properly qualified nurses to its junior Class, thus giving two years of college credit for the three years of nursing training. Since 1916, no less than thirteen different colleges and universities have provided combined courses, through which students may acquire both a nurse's training and a college degree.

The combined course in such a school, for example, involves two years of ordinary college work including besides work of a liberal nature certain of the fundamental sciences basic in nursing education. Then follow two years of intensive training in the hospital and, finally, a fifth year of post-graduate education in one of the higher specialties of nursing, public health, institutional supervision or nursing education. At the close of training, the student receives a diploma in nursing and the bachelor's degree in nursing or in science.

This type of school of nursing should, in the judgment of the committee, be a separate and independent department of the university, cognate in rank and organization with the school of medicine or the school of law. It should have direct responsibility for all instruction given during the years of hospital training and the post-graduate nursing year.

A definite affiliation with one or more hospitals must in any case be established, along the line of these agreements now in force between medical schools and hospitals. The school supplies student nursing service and assumes a definite responsibility for a larger or smaller share of ward supervision and perhaps of graduate service. The hospital, on the other hand, provides maintenance for the nursing staff and conforms to the standards held by the university to be essential for the realization of its educational ideals. A university hospital will of course offer the most promising field for a university school of nursing; but in default of such an institution there seems no reason why a university school should not establish satisfactory working agreements with various adjacent hospitals, provided only that the maintenance of adequate standards in the practice field remains in its own hands.

If its present practical functions be clearly understood the university school of nursing possesses unique advantages in respect to both of the essentials for success in nursing education, to which reference has been made in a preceding paragraph. It possesses the power of independent educational leadership and is grounded on the solid foundations of educational ideals, to a degree which a training school committee, ultimately responsible to board of hospital trustees, can seldom hope to realize; and it is likely to obtain financial resources of a more nearly adequate extent. Furthermore, through its university contacts the university school of nursing has unique opportunities to attract students of the type so greatly needed for the fulfillment of the higher tasks in the nursing of the future.

It should be made quite clear that the committee does not recommend that nursing schools in general should work toward the establishment of courses of a character that a university would accept for a degree. We realize that the numerical proportion of the nursing profession to be contributed by the university school will perhaps always be a relatively small one. Yet we believe that the importance of this portion of the educational structure would be difficult to overestimate. The value that we see at present in the university schools is that they will furnish a body of leaders who have the fundamental training essential in administrators, teachers and the like. One of the greatest, if not the greatest of the reasons for the imperfections in the present training of private duty nurses is that great numbers of schools have developed without any coincident development of adequate numbers of persons properly trained to guide the pupils during their course. Unless well taught they cannot be well trained. The university school of nursing should be the keystone of the entire arch. It will not only train leaders and develop and standardize procedures for all other schools, it will, by its permeating influence, give inspiration and balance to the movement as a whole and gradually but steadily improve the efficiency of every institution for the training of nurses of whatever type. We would therefore urge as

Conclusion 8. That the development and strengthening of University Schools of Nursing of a high grade for the training of leaders is of fundamental importance in the furtherance of nursing education.

Educating the Subsidiary Type of Nurse

We have pointed out in a preceding section of this report that there appears to be a real place for nursing service of a subsidiary type, to be used in the institution and in the home, for the routine care of patients suffering from disease of a mild or chronic type or in convalescence. We have also pointed out that this subsidiary service is an existing fact, whether we like it or no.

Existing facilities for the training of the subsidiary worker are today of the most limited type. It is obvious that courses in home nursing of a few weeks' duration, such as those conducted under the auspices of the American Red Cross, while most useful in disseminating the sort of knowledge which all girls and women should possess, in no way suffice as preparation for the practice of a profession. When they are advertised as adequate for this latter end, such courses may do far more harm than good—as evidenced by the fact that "graduates" of such courses, after forty-eight hours of training, have practiced as qualified nurses and received $5 a day for their services.

Courses for the training of nursing aides offered by the Household Nursing Association of Boston and by local Young Women's Christian Associations in various parts of the country and those stimulated by the Bureau for the Home Care of the Sick under the Thomas Thompson Trust are on a wholly different basis. The number of graduates from such courses is, however, small and their control after graduation loose and unsatisfactory. Since the existence of the subsidiary nursing group is a concrete fact, and in view of the valuable results to be derived from the service of this group in a definitely restricted field, it seems obvious that specific provision should be made for the training of workers of this type.

The field for the training of nursing aides would seem to be an ample one. The special hospital not served by affiliation with a school of nursing, and the small general hospital whose facilities are inadequate for the maintenance of a nursing school of standard grade might be considered as training grounds. In the large general hospital whose opportunities are not fully utilized by student nurses there is no valid objection to the training of the subsidiary group, provided that it is conducted in separate and distinct wards so that the sacrifice of the interests of either of the two groups of pupils may be avoided. The requirement for entrance should be a grammar school course or its equivalent and the period of training approximately eight or nine

months. Suggestions of great value in regard to the safeguarding of such a course for "trained attendants" will be found in a recent report issued by the board of regents of the University of the State of New York.

It is essential in providing for this new type of education that hospital patients should be protected from malpractice and students from exploitation by an adequate graduate nursing service for the care of acute illness and for supervision of the students. Again, therefore, we must assume a reasonable financial support before this or any other educational enterprise can be honestly undertaken. Furthermore, we believe that a useful development in the training of nursing aides can only be expected when the standards of the schools for such aides and their activities after graduation are controlled by a properly safeguarded system of state legislation, such as now exists in Missouri*. With these assumptions we would recommend as

Conclusion 9. That when the licensure of a subsidiary grade of nursing service is provided for, the establishment of training courses in preparation for such service is highly desirable; that such courses should be conducted in special hospitals, in small unaffiliated general hospitals or in separate sections of hospitals where nurses are also trained; and that the course should be of eight or nine months duration, provided the standards of such schools be approved by the same educational board which governs nursing training schools.

The Financial Problem

We believe that the educational plan which has been outlined above is, according to existing information, necessary and sufficient for the solution of the problems involved in securing an adequate nursing service of all essential types. The school for nursing aides would provide the subsidiary worker needed for the care of the mild and chronic convalescent case. The hospital training school, with adequate funds and an independent educational organization, would attract more candidates and better candidates and would prepare them adequately for the nursing of acute disease. The university school of nursing would prepare the leaders in public health nursing, in hospital supervision and nursing education and would inspire and standardize the entire movement. Progress must be made gradually, of course, building up for the future, step by step, upon the basis of existing facilities.

It is clear, however, that the attainment of these ends requires financial support, and requires it at all points along the line. The training of nursing aides will cost money, the training of nurses will cost more money, the university school will require endowment on a reasonably generous scale. The hospital, in its operation of the training school has for generations been trying to make bricks without straw, in the upbuilding of an educational system on an apprentice basis and without independent educational resources. It has made every possible effort—except the effort to secure educational endowment. It is time that the hospital should be relieved from the dilemma of exploiting student nurses on the one hand, or of diverting funds given for the care of the sick on the other, by the provision of endowment specifically devoted to the purposes of education.

We are well aware that many of those who have taken counsel with us in regard to this matter have cherished the hope that the committee would find some magic pathway out of the maze of nursing education; but such hopes are vain. There is no short cut to the end which we all have in view. The establishment of a sound educational policy is the one essential to attracting students in quantity and of quality; and a sound educational policy requires specific financial support. If the community needs and desires the service of competent nurses for the care of the sick and the prosecution of the campaign of public health, it must pay for their education, as it pays for every other conceivable kind of education—either through taxes or through voluntary contributions or through the generosity of its great philanthropic foundations. No broadly conceived and systematic effort to obtain such financial support for nursing education has ever yet been made. When it is made we are convinced that it will not fail. In institutions where nursing education has been even partially endowed, as in the first school of nursing at St. Thomas' Hospital, London, and the Department of Nursing and Health at Teachers College, New York, substantial achievements in the better education of nurses have been rendered possible.

It is obvious that the plan recommended for improvement of the education of nurses cannot be adequately put into effect in any hospital training school without additional funds for this purpose. The strategic position which the university schools of nursing will occupy in regard to the whole movement indicates their development as of special importance. An adequate endowment for a group of such university schools would establish centers of influence which could safely be trusted to exert a profound influence upon nursing education. We, therefore, urge as the final conclusion from our study of this problem:

Conclusion 10. That the development of nursing service adequate for the care of the sick and for the conduct of the modern public health campaign demands as an absolute prerequisite the securing of funds for the endowment of nursing education of all types; and that it is of primary importance, in this connection, to provide reasonably generous endowment for university schools of nursing.

*The Missouri act is unusually effective in providing that "no person shall practice as a nurse for hire or engage in the care of the sick as an attendant for hire unless licensed by the board as hereinafter provided."

MOUNT SINAI HOSPITAL, PHILADELPHIA, DEDICATES NEW BUILDING

Dedicatory exercises of the new building at Mount Sinai Hospital, Philadelphia, were held on June 25 in the presence of some 1,500 guests of the hospital. The addition to the hospital cost $175,000 and contains among other departments a group of five laboratories: chemical, serological, histopathological, metabolism and animal experimentation.

The new building completes a five and one-half story structure and increases the capacity of the hospital to 161 beds. The fourth floor, built for private patients, is now being utilized as nurses' quarters awaiting the erection of a new nurses' residence. A roof garden of more than 3,000 square feet overlooks the neighborhood and provides a delightful outlook for convalescent patients.

The Mount Sinai Hospital possesses one of the largest out-patient departments in the state of Pennsylvania. More than 75,000 cases are treated annually in twenty-two clinics. An additional dispensary building is to be erected soon through a gift from Mr. William Lipkin. This will increase the out-patient capacity of the hospital to between 125,000 and 150,000 cases per year.

Owing to its central location in the city, the hospital treats thousands of accident cases. The plans are now being developed to erect larger and more convenient accident rooms and ambulance appointments.

LEAVES NEW HAVEN HOSPITAL

Dr. Harold W. Hersey has resigned as head of the New Haven Hospital and has become affiliated with the administrative board of Columbia University and the Presbyterian Hospital.

"This power of teaching oneself is one of the elementary essentials in acquiring useful knowledge of psychology."—Aileen Cleveland Higgins.

AN OBSERVATION HOSPITAL AND DAY SCHOOL FOR TUBERCULOUS CHILDREN

By F. E. HARRINGTON, M.D., LL.D., Commissioner of Public Health and Director of Hygiene, Minneapolis, and WALTER E. LIST, M.D., Superintendent, Minneapolis General Hospitals, Minneapolis.

IN 1912 George R. and Frederick W. Lyman deeded to the city of Minneapolis a tract of land containing 78,525 square feet on which stood the Lyman homestead, a spacious, old-fashioned house equipped with all modern improvements. In the rear of this building was another residence, smaller in size but modern in appointments. This donation to the city was made for the operation of a children's hospital and became the pediatric branch of the City Hospital. Some remodeling was done and the much overcrowded children's wards of the City Hospital were transferred to the new institution.

The board of charities and corrections, an executive board of the city of Minneapolis having charge and jurisdiction over hospitals, in 1917 moved the hospital building to the rear of the lot beside the smaller residence and began the building named "Lymanhurst"; which was completed April 1, 1921 at a cost of $265,000; it became the pediatric hospital branch of the general hospital system of the city.

This modern hospital building faces east and stands back seventy feet from the property line, giving large grass plots with numerous trees in the foreground. The building is 205 feet long and is constructed on the central administration plan with north and south wings, the wings being 37 feet from front to rear and the main building 67 feet in depth and 50 feet in width for that portion extending to the front and rear wing lines. On the north entrance a cement drive from the street has been constructed for ambulance service. The boiler room and power house are located some 65 feet in the rear of the building connected therewith by tunnel and accessible for coal deposits and ash removal.

The entire grounds have been landscaped and are naturally beautified by large shade trees; cement walks have been constructed. The building stands two stories above the ground floor. It is built of cement brick with cement cornices and trimmings. Being open on all sides it is about 80 feet from the nearest building, excepting the power house, adequate ventilation and light are provided.

A day school and observation hospital combined is Lymanhurst in Minneapolis.

At the time the building was turned over by the committee in charge of construction to the department of public welfare as completed and ready for occupancy, it was found impossible to man the building properly because of the shortage of nurses and because of the absence of adequate housing facilities for nurses' home. The building was designed as an eighty-six bed children's hospital. It was not possible to obtain sufficient nurses to serve an institution of that size.

In anticipation of the completion of the building and with a realization of conditions existing with relation to the nursing force the commissioner of public health and director of hygiene brought about a joint agreement between the board of public welfare directing the division of

public health and the division of hospitals, and the board of education directing the department of hygiene. This agreement was to the effect that Lymanhurst was to be opened as an open air school for the education and care of children of

Five of the pupil-patients at Lymanhurst are receiving their sun lamp treatment.

school age with active lesions of tuberculosis.

The problem of childhood tuberculosis had been a subject of study and it developed that something over 120 children were at one time being carried on the records of the communicable disease section of the division of public health as active tuberculous cases. Many of them were too sick to attend school and required hospital or sanatorium care. There was under construction at this time on the grounds of the Hennepin County Tuberculosis Sanatorium at Glen Lake a sixty-bed children's hospital so the application of the idea to Lymanhurst was restricted to children who were able to attend school but who because of their infection were potentially a danger to other children and who under the state law would not be permitted to attend the regular schools of the city. The building is especially adapted to this character of work, is modern in every particular and is arranged as follows:

General Plan of Building

In the central or administration section on the ground floor are the school cloakrooms and a modern, fully equipped x-ray outfit including dark room and technician's office. In this section of the building is located an automatic, electrically controlled elevator. On the main or entrance floor of the central section are the waiting room, director's office, supervisor's office, school principal's office, admitting desk and telephone switchboard with information clerk and a retiring room which has been assigned to the teachers of the school. This room is completely equipped including lavatory, shower and toilet.

On the second floor of the administration section are located the school nurse's hygiene room, the general physician's examining room, the dressing room and alpine lamp treatment room with two large wards facing east and opening onto a large sleeping porch, each room equipped with toilet facilities.

The roof of the administration section is on the same plane with the roof of the wings, is flat, reached by the electric elevator with possibilities of development as a roof sun bath treatment and playground. In the south wing opening on three sides permitting thorough ventilation are sunlight exposure and natural illumination. On the ground floor are located the shower room with dressing rooms capable of accommodating thirteen children at one time, three large dining rooms with serving room and kitchen equipment with all modern hospital dietary apparatus and ventilated by forced electrical ventilators.

On the main or entrance floor of this wing are the classrooms in conjunction with which are a kindergarten room, book and stationery storage and a toilet room each for boys and girls. The main classroom is about 75 by 70 feet, open on the east and west exposures with a smaller room designated as an enclosed porch open on three sides and facing south with two smaller study or recitation rooms on the east and west exposures between the main classroom and the enclosed

All pupils at Lymanhurst retire to their cots after luncheon, where they sleep until 2:30 before returning to the classroom.

porch classroom. On the second floor of the same wing with approximately the same arrangement are the cot rooms, (excepting the enclosed porch which is being used as an additional classroom), in which children are given their one-hour rest period. These rooms are also supplied with proper toilet facilities for boys and girls.

The two front rooms of the central section on this floor and the sleeping porch are also used as cot spaces. Classrooms on both floors are equipped with portable desks and blackboards and can accommodate 125 pupils.

All of the equipment for school purposes is furnished by the board of education. The cot rooms are equipped with a portable folding cot with pillow and slip, sheets and two large, double all-wool eight-pound blankets.

On the north wing on the ground floor are the storerooms for provisions and a large cold storage refrigerator, the shipping room with entrance at the rear, the laboratory, locker and toilet room for employes, diet rooms for personnel both staff and employes, and an isolation room with an outside entrance with toilet and diet kitchen connected for the care of suspected communicable diseases until their removal to the isolation hospital.

On the first or main floor of this wing to which leads the ambulance entrance, as previously described, are five wards and three physical examination rooms, the former being used as overflow cot rooms and the latter accommodating the activities of the out-patient dispensary service. All persons use the north or ambulance entrance which brings them directly into the dispensary quarters. On the second floor of this wing are located four lateral wards and one large end ward corresponding to the enclosed porch classrooms at the south end of the building. The two wards facing west with the porch ward accommodate twenty beds, and two wards facing east are used for the nurses' room and the patients' reception room. Adequate toilet facilities are provided in this section as well as diet kitchens and property lockers.

In the basement or cellar of the building is the large autoclave sterilizer, storerooms, elevator, engine and refrigerating plant supplying refrigeration for cold storage and other refrigerators throughout the building, all drinking fountains located in each wing on each floor, and for the manufacture of ice for the hospital consumption. Hot water is supplied from the boiler building and steam heat throughout the entire building. The central section is cut off from either wing by a series of vestibule doors with small stairway leading from the vestibules on either wing between the first and second floors. The main stairway is in the central section of the building, leading from basement floor to the roof beside the elevator shaft.

Is Well Furnished and Equipped

The entire building is of fireproof construction; all floors are cement block and the walls to a heighth of five feet on the ground floor are plastered with a cement plaster. All partitions are hollow tile plastered and partitions between wards are clear glass panelled, virtually throwing each wing into a single ward. Lighting facilities are adequate, the lights being controlled from a central switchbox on each floor and wall switches in each ward or room.

The tintings of the walls are of a neutral color, pleasing to the eye, bright enough to be non-light absorbing, easily cleaned, and harmonize with the finish of the woodwork which is mahogany throughout the central section, and mahogany doors with white door and window frames throughout the wings.

All equipment, upkeep and operating expenses other than the furnishings especially designed for the school work are included in the operating and equipment budget of the hospital section of the department of public welfare. The director of hygiene and commissioner of public health jointly with the superintendent of hospitals operate and

A ward at Lymanhurst.

The Lymanhurst kitchen.

supervise Lymanhurst with a personnel consisting of a principal, four teachers, a hygiene nurse furnished by the board of education, a supervising nurse who is in immediate charge, three graduate nurses and two undergraduate nurses, a laboratory technician in charge of the laboratory and x-ray departments, a clerk, a telephone operator and information clerk, together with cooks, maids, orderlies, janitors and the proper engineering force. The building, of course, is under active operation twenty-four hours each day.

More immediately associated with the director of hygiene and commissioner of health is a staff of twenty specialists covering the following fields:

Otorhinolaryngologist	Hematologist	Roentgenologist
Cardiologist	Neurologist	Dermatologist
Orthopedist	Pediatrist	Bacteriologist
Ophthalmologist	Gastro-enterologist	Thyroid disorders
Anatomist		General tuberculosis

This is a volunteer staff and supervises directly all physical examinations and treatments. It is possible to obtain the services of the men of their character and standing because of the unusual offerings for the study of children.

Same Work as Public Schools

The Lymanhurst School has been established by the board of education as a regular open air opportunity school. The course of study and curriculum embraces all grades exclusive of kindergarten and high school, although high school grades can be taught and will be taught should occasion arise. At the present time all grades from the first to the eighth inclusive are taught at Lymanhurst. Children maintain their standing with the grades of the other schools and can enter or leave Lymanhurst at any period of the school year without detriment to their scholastic standing and this condition of affairs actually does exist. Children are admitted to Lymanhurst and discharged from Lymanhurst at any time during the school year as occasion demands.

Any child who has been definitely diagnosed as actively infected with tuberculosis, even though not definitely an open case, is admitted to Lymanhurst upon the certificate and report of the attending physician or clinic. Children showing signs or symptoms suspicious of tuberculosis infection are examined in the out-patient service which service is restricted to children of school age suspiciously tuberculous. Von Pirquet tests are applied and x-ray plates are made of each child and a confirmatory or definite diagnosis admits the child to Lymanhurst School. Only children who are able to attend the regular school sessions are admitted. Children unable because of their physical condition to travel to and from the school at the regular school hours of 8:45 to 3:15 are referred for admission to the County Sanatorium at Glen Lake. No child once diagnosed is permitted to attend the regular schools of the city and if able must under the compulsory education law of Minnesota attend Lymanhurst. The carfare to and from school for all children traveling on the street cars is paid by the board of education. There are no other methods of transportation provided.

Once a child is admitted to Lymanhurst as a student a routine physical examination is made by the staff both as a coordinating diagnosis and as a matter of study. With full consent of the parents each specialist makes a research study of the child and periodically these findings are compiled into a symposium report. The child is under constant supervision and any conditions arising of interest are reported to the chief of staff and further examinations or studies are made; or, when advisable either from the standpoint of the physical condition of the child or for more intensive

The temperature in the Lymanhurst school room is about forty-five degrees, which explains the Eskimo costumes.

observation, children are placed in the ward for a limited period. If after careful observation as a ward patient the child becomes a candidate for sanatorium treatment an application is made and the child transferred to the County Sanatorium at Glen Lake. Upon improvement, however, the child is returned to the day school attendance. Under direction of the staff such treatment as may be indicated is instituted for all children requiring treatment.

Sun lamp treatment in a room equipped with two Hanovia quartz lamps, able to treat six children at one time, is given and all children in the school are given shower baths twice weekly. Diet is carefully supervised and the preparation of food is under the immediate supervision of the supervising nurse.

Daily Program at Lymanhurst

The daily program at Lymanhurst is as follows:

Children arrive and are admitted and at 8:45 are given a light diet consisting usually of a cereal or gruel with milk, and in cold weather hot milk or cocoa. Classes convene at 9:00 and continue until 11:00. The recess period is between 11:00 and 11:30 and children are again given a light diet during the recess period before returning to the classroom. At 12:30 the children pass through the toilet and wash rooms to the dining rooms where a full meal is served. This meal consists of a soup, a meat, vegetables, a properly selected green salad, bread and butter, milk, (no tea or coffee) and a dessert. From the dining rooms the children proceed immediately to their cots where they sleep until 2:30. From 2:30 until 3:15 class is again held. At 3:15 the children are dismissed, again receiving a light diet.

The school curriculum is so arranged that daily between the hours of 9:00 and 12:30 an entire class is excused from recitation or study and it is during these hours that the children are subjected to examinations, bathing, sun lamp treatment and weighing. Temperatures are taken daily of all children during the last forty-five minute period.

The records of Lymanhurst are voluminous, each member of the staff making a record of the findings of the examination conducted by him, and these records are bound and become material for study and research investigation.

As rapidly as children are found to have approached a reasonable norm their case is studied by the entire staff and, if advisable, the child is returned to the school of the district in which he lives.

All classroom and sleeping room periods are conducted with open windows, the children and teachers being supplied with eskimo suits comprising heavy felt lumbermen's boots, bloomers and reefer coats with hoods made of heavy, long fiber, all wool material. These the children wear in class as well as on their cots. Although fresh air is desirable, too low a temperature is not advantageous, so with the steam heating plant in operation the windows are opened sufficiently to produce a constant change of air but with the idea of maintaining a temperature as nearly 45 degrees F. as possible.

With the close of the first year of Lymanhurst the records show that there have been admitted to the school 199 children, and discharged therefrom sixty-five children. Since the opening of the out-patient dispensary service on January 24, 1922, 222 children have been examined, and since the opening of the observation wards thirty-one children have been admitted and nineteen children discharged. Out of the nineteen children discharged, five went to the Glen Lake Sanatorium.

Lymanhurst fits into the scheme of tuberculosis prevention as an intermediary between the normal child and the child needing institutional hospitalization.

"THE FOUR HUNDRED" OF THE BOSTON DISPENSARY HEALTH CLINIC

The Boston Dispensary Health Clinic has published recently a most readable little four-page pamphlet entitled "The Four Hundred." This bit of publicity is illustrated by tiny line drawings, showing "tooth pick" figures in all sorts of animated poses.

"The four hundred" of this diagnostic clinic are the first 400 individuals who visited it. Of these 320 were presumably well when they came to the clinic for physical examination. They came to be looked over, as an ordinary precaution.

Exclusive of eye, ear, nose and throat troubles, 316 of these individuals were found to have physical defects requiring treatment. One-half of them confessed to bad health habits, and in thirty per cent of them were found well recognized factors leading to organic disease.

The clinic provides for wage earners, who are troubled about their health or want to prevent trouble, expert medical examination and advice. For the complete examination the fee is $5. No treatment is given.

SUPERINTENDENT JOINS MEDICAL STAFF AND TRUSTEES

The superintendent of the Beth Israel Hospital, New York City, is a member ex-officio and secretary of the board of directors, the medical board, and every committee of the board of directors and the medical board. In his official capacity, therefore, he attends all meetings of the trustees and the medical staff thus interlocking both boards.

VISITS EUROPEAN HOSPITALS

Dr. Walter H. Conley, medical superintendent of the Metropolitan Hospital, Department of Public Welfare New York, sailed in June to visit hospitals in Italy, Switzerland, France, Belgium and England.

SELECTION OF A TUBERCULOSIS HOSPITAL SITE: AN ENGINEERING VIEWPOINT

By E. S. CHASE, Sanitary Engineer, with Metcalf & Eddy, Consulting Engineers, Boston, Mass.

THE selection of a site for a tuberculosis hospital presents a problem which requires careful study from various viewpoints—political, sociological, legal, financial, architectural and engineering, as well as medical and administrative. It is therefore necessary in considering the problem from the engineering viewpoint not to overlook entirely these other viewpoints.

The primary factors involved in the selection of a site are: accessibility, topographical features, locations for buildings, water supply and sewage disposal.

Accessibility

The first of the essential requirements for a satisfactory site is ease of access not only for the patients themselves, but also for visiting relatives and friends. In general a site should be close to the transportation center of the population contributing to the hospital. Furthermore the character of the transportation facilities available must be such that the cost of railroad fares will be kept at a minimum. The site should also be located comparatively near the railroad station and the condition of the local roads between the station and the site must be satisfactory or capable of being made satisfactory. The accessibility and the condition of the local roads are important factors not only from sociological and administrative viewpoints but also in connection with the cost of the hospital, as the more accessible the site and the more satisfactory the highway conditions, the lower will be the first cost of construction.

Electric light and power facilities as well as readily connected gas mains are desirable. Nearby sources of building material and supplies are an additional advantage.

Topographical Features

While not absolutely essential it is on the whole better to select a side hill location somewhat above the elevation of the surrounding country.

The number of acres required depends upon the number of patients to be accommodated and the extent of buildings to be erected. Too small an area often involves the location of the hospital in close proximity to neighboring properties and the cramping of the necessary hospital buildings into a space too small for satisfactory architectural and administrative grouping. Under no condition should there be in the vicinity any considerable amount of marsh land or low-lying spots in which mosquito breeding pools may exist.

Insofar as the hospital itself is concerned the character of the soil is of relatively small importance, although as will be referred to later, it is of great importance in connection with the problem of sewage disposal. A well-draining, sandy soil is preferable to an impervious clay soil. Ledge, of course, is usually unsatisfactory due to its disadvantageous effect on construction costs and the difficulty of subsequent development of the hospital grounds.

A high elevation above sea level, which at one time was considered an essential requirement, is no longer thought to be a paramount significance, but clean pure air, free from dust and excessive humidity, is essential.

Building Sites

The property selected must afford satisfactory locations for the various buildings required. Generally speaking, the building site should be on a side hill, preferably facing the southeast, with proper shelter conditions provided either by the hill rising to the northwest of the site or by adequate wind break of evergreen trees. Although the building site should be on a side hill and not on low or level land, it is also very desirable that the approach to the buildings from the main highway shall not be of undue length nor of undue steepness. The outlook over the adjacent country should be pleasing.

As a rule there is no particular advantage in selecting a site with existing buildings, due to the fact that the special needs of tuberculosis hospitals are such that it is not wise to attempt the conversion of existing houses for hospital purposes.

Water Supply

It is absolutely necessary that the site selected shall be such that an adequate supply of water of unquestionably satisfactory physical and sanitary quality can be obtained. In case the site is located in the vicinity of a municipality having a satisfactory water supply, the solution of the problem is simple. In such a case all that is necessary under ordinary conditions is the extension of a main from the distribution system of the municipality.

On the other hand when such a happy solution cannot be found it becomes necessary to consider sources of water supply upon the site itself or in close proximity to the site. In general from small hospitals the water supply can best be obtained by the development of wells, in this way securing a supply located reasonably close to the hospital and one usually less difficult to protect from possible pollution. Unfortunately, however, ground water supplies are the ones about which it is most difficult to predict in advance as to quality and quantity. The topographical features and the character of the soil afford some indication as to the possibility of developing adequate ground water sources of supply. Wells can usually be developed in sand and gravel soils in the valleys of streams or at some low point where the surface topography indicates the possible or probable confluence of ground water flows. A sanitary inspection of a proposed ground water development will also afford fairly definite evidence as to its probable sanitary quality.

Even with excellent surface indications of successful ground water development, it is always advisable to sink test wells to determine more surely the ground water resources of the site and to obtain samples for analysis. In fact no site should ever be purchased until adequate assurance of a satisfactory water supply is obtained.

In considering the water supply problem the necessity for fire protection must not be lost sight of. This involves provision for adequate storage to deliver the necessary fire streams when required. In some cases the topographical features of the site are such that a covered reservoir of masonry construction may be located at an elevation to give the requisite water pressure at the hospital. In other cases it may be found necessary to construct steel tanks on elevated towers.

Sewage Disposal

Not only is it essential to secure an adequate water supply but the site selected must be such that the disposal of the sewage from the institution can be accomplished without danger to health or the production of local nuisance as regards the hospital and neighboring property.

In case of a site in the vicinity of a municipality with a sewerage system the problem may be solved by the simple means of running a sewer extension from the municipal system to that of the hospital. On the other hand when such a course is not possible it becomes incumbent upon the hospital to have a proper sewage treatment plant of its own. If the soil is satisfactory and the size of the hospital is not too great, one of the most satisfactory methods of sewage disposal is by means of settling tanks followed by subsurface irrigation. This method of disposal, however, requires soil of satisfactory character and sufficient area available for such a system. Sandy or gravelly soil is best adapted for this mode of treatment, while clay and other impervious soils are not at all suitable. It is always possible, however, to construct small intermittent sand filters if the site is of sufficient size and the location of the filters such as to cause no locally objectionable conditions.

The method of treatment and the possible location of the treatment plant must be such as to afford no opportunity for pollution of the hospital's or any other water supply.

The location of the hospital on a watershed tributary to any public water supply, except in the case of an extremely large watershed, is inadvisable on account of the danger of pollution by sewage from the hospital and by surface wash from the hospital grounds. It would, of course, be possible to provide chlorination for the effluent from the sewage treatment plant, as is done in the case of certain institutions on the Croton watershed of New York City. In view of the difficulty of securing proper and continuous operation of the disposal plant it is on the whole inadvisable to select a site which would require a complicated method of sewage treatment.

From the foregoing it is evident that the utmost care and forethought must be exercised in the selection of a site for a tuberculosis hospital. The practice followed by the New York State Department of Health* in having inspections of proposed sites made by a physician, an architect and an engineer is one worthy of adoption in all cases prior to the final selection of a site.

LONDON HAS HOSPITAL WEEK

London last month had a Hospital Week celebration, the chief features of which were a Hospital procession past Buckingham Palace, a pageant and carnival. The procession was held on July 1 and was the chief event of the Combined Appeals for the Hospitals of London and was a series of tableaux carried on lorries, showing the history of hospitals from the monkish healing of the Middle Ages to the perfected methods of the present day.

Before putting on the week's observance, which was a scheme of collective publicity for the voluntary hospitals, the boards of governors of eighty per cent of the bed accommodation and out-patient attendances of the London voluntary hospitals gave their approval to the project which was carried out under the auspices of the King Edward's Hospital Fund for London.

*Acknowledgement is made of the information from and friendly cooperation of Dr. O. R. Eichel, Dr. E. S. McSweeney and the late Dr. M. E. Rose, former supervisors of tuberculosis, and Mr. A. L. Burt, architect, of the New York State Department of Health.

THE NEW PRIVATE PAVILION OF MOUNT SINAI HOSPITAL, NEW YORK

By ARNOLD W. BRUNNER, Architect, and S. S. GOLDWATER, M.D., Consultant, New York.

IT IS our purpose in this article to present briefly the distinctive features of the private patients' pavilion of the Mount Sinai Hospital of New York, a building designed for the care of 131 private patients. Since no building which is part of a hospital group can be properly evaluated without a clear understanding of surrounding conditions, a preliminary statement of the physical and other conditions which affected the problem of planning is in order.

The available plot was 200x70 feet, its long axis extending approximately north and south. The westerly margin of the plot coincides with the building line of Fifth Avenue and faces Central Park. East of the site are two low hospital buildings, only 30 feet high; between them and opposite the center of the proposed private pavilion is a broad grassy court depressed to the level of the basement windows. North and south are city streets sixty feet wide.

Interior connection with the other structures belonging to the hospital group could be obtained only by means of basement and sub-basement corridors. The pipe tunnel has been placed on the sub-basement level, and the basement corridor is finished in a manner appropriate to its use, which is confined to the movement of hospital personnel and the transportation of patients and supplies.

The new pavilion is served by the hospital's central power, heating and refrigerating plants, laundry and laboratories. Pupils and graduate nurses employed in the pavilion lodge in the nurses' home; the domestic servants share the hospital's near-by dormitory building. In the private pavilion itself are quarters for the resident medical staff, a kitchen, four operating rooms, business offices, and locker and dressing rooms for non-resident graduate nurses.

Mount Sinai Hospital's new private pavilion, which embodies 1,400,000 cubic feet of fireproof construction.

Seven Full Floors Above Street

The new building has, above the street level, seven full floors which are occupied in whole or in part by patients. The northerly section of the first floor is given over to business offices, reception rooms, and rooms for the resident staff, while the corresponding section of the seventh floor has been appropriated for the operating rooms and their accessories. The whole of the eighth or roof

story, with the exception of a room containing two pairs of fifty-gallon water sterilizers equipped with recording thermometers, is designed for the use of convalescent patients; on this level are a large solarium, a smoking.room, loggias, and extensive uncovered flat roof spaces surrounded by a low parapet which is surmounted by a five-foot railing. On this level are toilets for men and women, a small pantry, and a storeroom for roof furniture. Ventilating machinery, gathered in an attic above the solarium, includes separate exhaust fans for operating rooms, patients' rooms, kitchens and toilets. In the attic also are compressed air and vacuum machines which supply the operating rooms. Sterile water is piped from the water sterilizers on the eighth floor to the operating rooms on the seventh.

The principal rooms in the basement are the kitchen; a special nurses' dining room in which 112 nurses may be seated at one time; and a nurses' locker room, containing a hundred twenty-four inch lockers and ten dressing booths, with shower room adjoining. Kitchen storerooms and workrooms, cafeteria serving room for nurses, dining room for the kitchen help, and locker and toilet rooms for non-resident male and female domestics are also found on the basement floor. The ceiling height of these latter rooms is only half that of the great kitchen and the large dining room; the remaining space is occupied by a half-length mezzanine story, which is exclusively the territory of the housekeeper. Here there are separate rooms for the storage of linens, mattresses and pillows, furniture, rugs, and miscellaneous housekeeping supplies, together with a special room for the vacuum cleaning of rugs.

The west front of the building has been set back five feet from the building line in order to introduce a basement area and thus to provide direct light and air to the west front of the basement and mezzanine floors; inasmuch as the east front of the basement looks out on the depressed court already referred to, the two stories below the street level are well lighted and ventilated.

The entrance of the building is at the center of the block. The marble-lined vestibule is 15x30 feet. Three arches, filled in with plate glass openings, hung with silk curtains, separate the vestibule from the interior corridor. Four steps lead to the first floor level. An information desk faces the entering visitor who, turning to the right, finds himself in a short transverse corridor with reception room and parlor on one side, and visitors' elevator on the other. The front office is divided by low glass partitions, mounted on sanitary copper legs, into three sections, occupied respectively by the information clerk and telephone operator, the cashier, and the supervisor of the building. Adjoining the office is a room for the clinical historian. A near-by rear entrance is for stretcher cases.

The southerly half of the first floor is a patients' section corresponding with the southerly part of the middle or typical floors, which will now be described.

Corridor in Three Sections

How to overcome the monotony of a corridor 200 feet long was one of the problems dealt with in planning the typical floors. The answer was to divide this long corridor into three sections; the office and service section (about fifty feet long) was placed in the middle, with two patients' sections each approximately 75 feet long at the extremities. Each corridor section has one or more outside windows. The corridor ceilings are slightly arched, and for artistic as well as acoustic reasons are divided into sections by slightly projecting transverse bands of plaster. The floors of the corridor adjacent to patients' rooms, are finished with inlaid battleship linoleum, except that on the first floor rubber tile was used as a substitute; in all corridors there are borders and sanitary bases of terrazzo.

Ceiling fixtures for the ordinary illumination of the corridors are supplemented by night lights, installed in flush metal boxes twenty inches from the floor; so far as we know, this is the first use of this lighting device in a hospital. The door trim is of metal. Flush metal door jambs, finished in cream colored enamel, contrasting pleasantly with the mahogany-finished doors, are used throughout.

Of the twenty-two rooms on each typical floor four have private baths and toilets and two have private toilets. Each watercloset has a bedpan washing device. There are sixteen rooms on each floor which require outside bedpan service; for this service two utility rooms have been placed on every floor, each utility room central to a seventy-five foot corridor section; bedpan traffic through the corridors has thus been minimized, and the necessity of carrying bedpans across the central office and service section has been avoided. The utility room equipment includes a bedpan sink, wash tray with marble drain board, gas heater, ventilated metal specimen closet, utensil sterilizer, instrument sterilizer, steam-heated cabinet, marble solution shelves and water sterilizers. Every fixture in the utility room is hung on brackets. Here and elsewhere throughout the building all metal fittings above the rims of sinks are solid white metal; all fittings below, of painted brass.

A fireproof exit stairs is found at the middle of each patients' section; the stairways are constructed of steel with mastic treads.

IN CONSTRUCTION AND EQUIPMENT MT. SINAI PAVILION IS WHOLLY MODERN

The solarium of the new pavilion (center) is finished in richly colored tiles with a polychrome frieze below the arched ceiling. Above may be seen a service corridor, and a chartroom with a nurses' retiring room to the right and a visitors' sitting room in the background; below are views of the kitchen and a typical patient's room.

In planning the central or service section and in equipping patients' rooms, familiar models have been departed from. The main stem of the building is about forty-two feet wide. This width did not suffice to meet the requirements at the center. Here three cross corridors have been introduced. The middle of these three corridors terminates in a large central serving room. The serving room equipment, installed in duplicate to accommodate the large body of special nurses, consists of built-in refrigerator with exposed drain; gas stove, warming closet, and toaster — all on brackets—with hood and exhaust ventilating flue over; metal cupboard, mounted on sanitary tile base, with marble counter shelf and dish closet above; built-in metal garbage and dish cloth closets ventilated by heating or cooking devices which the hospital may desire to install in the future. In the center of each room is a monel metal work table with tray rack above. The serving room has a quarry tile floor and a white tile wainscot five and one-half feet high, with a half-inch line of colored tile between the white tile wainscot and the plaster wall above. The metal doors and all the trim in this room are finished in olive green.

A close view of the loges and private balconies which are a distinctive feature of the new pavilion.

The food is brought to these serving rooms on specially constructed noiseless tray racks, fitted with ball bearing casters. For each tray there is a specially designed one-piece all-metal hot water plate for conveying hot dishes from the kitchen to patients' rooms. All of the patients' trays are set up in the main kitchen, and the portable tray racks are then taken by means of the freight elevator to the service rooms on the several floors. The assembled nurses carry the trays to the patients' rooms.

The east front of the new pavilion at Mount Sinai Hospital which looks out upon two low buildings and a depressed grass court.

louvres; double sink of unglazed porcelain with drain boards of the same material, all mounted on brackets. Electric receptacles are provided for

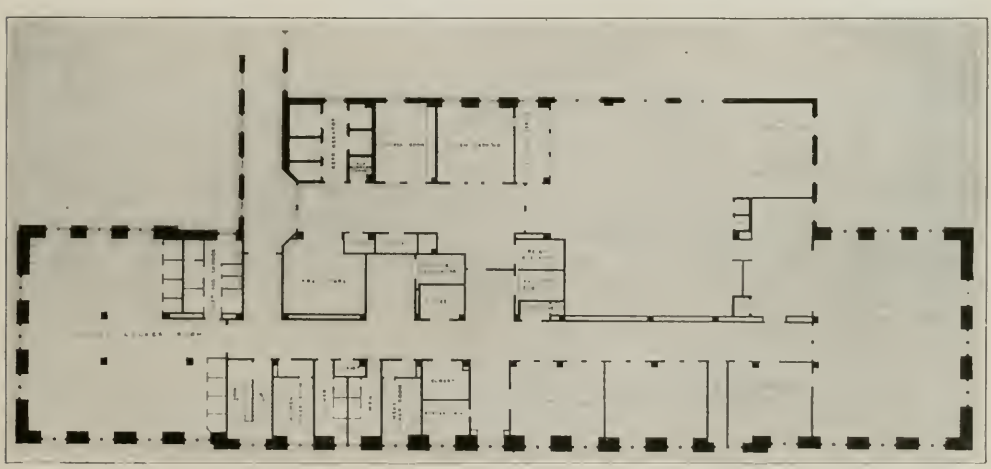
The side corridor, extending from the main corridor to the service room, is ten feet wide, and is flanked by linen and flower closets, an orderly's station, and two 5x8 foot elevators, one for freight, the other for patients and nurses; communication between the two elevator cabs may be effected, when necessary, by opening emergency doors. Double swinging hollow steel doors separate this corridor from the main corridor. The floor of the service corridor is of terrazzo. The floors of the linen closets are of painted cement. In the flower closets and utility rooms generally, floors are of gray and white ceramic tile.

Two minor side corridors, just off center, constitute important features of the plan. The first of these leads to a loggia which has a southern exposure; the second is a corridor in which visitors find themselves on leaving the visitors' elevator which, by the way, is designed exclusively for the use of visitors and physicians. As the visitor steps from the elevator into this well-lighted and ventilated side corridor, he is confronted on the right with a pleasantly furnished sitting room, on the left with an office and chart room. A new departure has been made in establishing on each floor an information clerk, whose station commands the corridor of approach. Calculation showed that on a floor of twenty-two private rooms the total amount of time spent by nurses in receiving visitors, packages, mail, telephone calls, etc., was fully equal to the whole time of one clerk. Inasmuch as this work is not really nursing, it seemed desirable to assign the work to a clerk, leaving the nurses to perform their proper duties. Opening off the chart room is a retiring room with toilet attached for those special nurses whose presence in their patients' rooms is not required. All of the administrative features which have just been described are centrally concentrated.

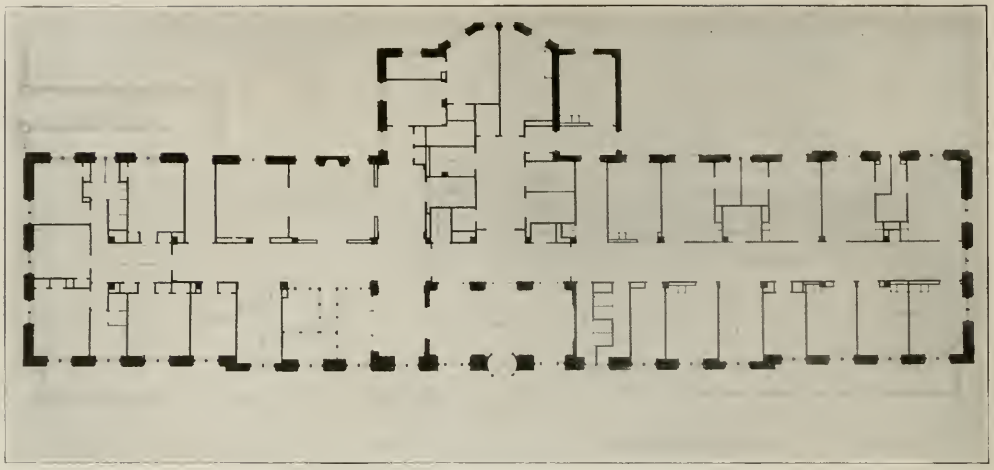
From the standpoint of the patient and the public the most interesting part of a private hospital is the patient's own room. In the new pavilion the rooms have floors of terrazzo, with sanitary base and bed stop. The walls are of plaster, delicately tinted. Hollow tile partitions have been used. The rooms which front on Fifth Avenue and overlook the park have double hung windows, with transoms operated by transom rods, and with ventilators inserted in the lower rail of the lower sash. The room doors are of veneered birch, finished like mahogany; they are four feet wide, and are equipped with hold-open, two-speed, absolutely silent door closers. The doorway to each patient's room has, in addition, a screen door, about five feet from top to bottom, hung 18″ from the floor so that its top is five feet six inches from the floor; the screen doors have wood frames filled in with casement cloth panels; each screen door has closing springs, and the closing of the door is made noiseless by means of generous felt bumpers.

Balcony for Each Patient

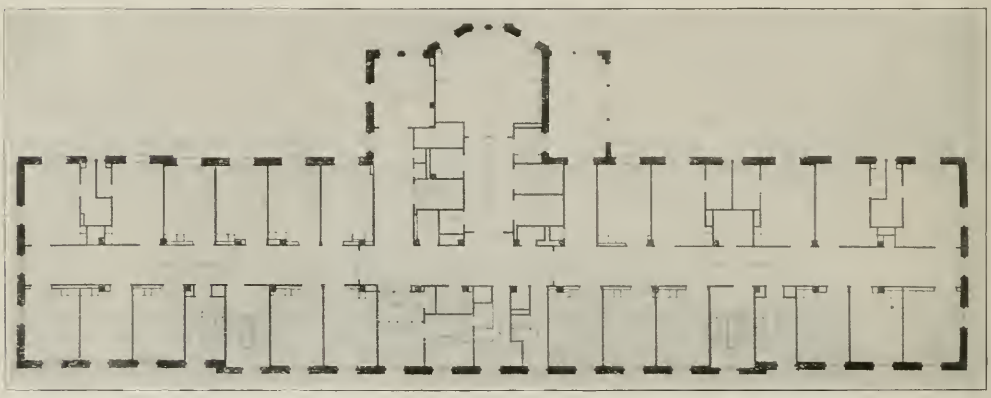
All of the rooms which overlook the hospital grounds have in lieu of ordinary windows, glazed casement doors with movable transoms above and adjustable ventilators below for winter ventilation. In the summer the doors may be folded back completely, making accessible a private balcony which is attached to each room. Patients may recline on wheel chairs placed lengthwise on these balconies, which are three feet wide, or the head of the bed may be pushed out-of-doors



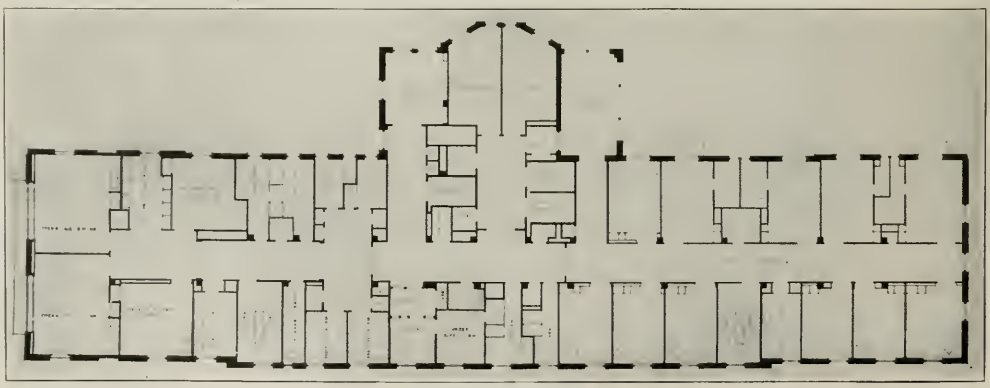
Basement floor plan.



First floor plan.

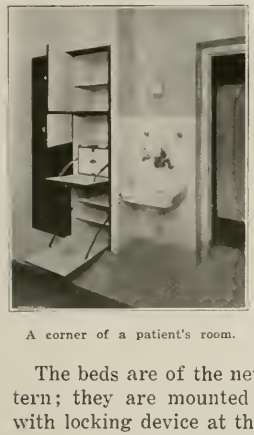


Typical floor plan.



Operating floor plan.

and the patient may thus enjoy the outer air without having to leave his bed. Outside of the casement doors collapsible green venetian blinds are hung. The inside sliding curtains, of tan casement cloth, were thoroughly shrunk before being installed. The body of the curtain corresponds in color to the warm tint of the walls, but each curtain has a bright-colored border. Each room has a mahogany dresser and bedside table; both of these have glass tops, covering colored dresser cloths. Three two-tone washable rugs, 3x5 feet, are provided for each room.



A corner of a patient's room.

The beds are of the new Hall-Mount Sinai pattern; they are mounted on ball-bearing casters with locking device at the foot, and are provided with Gatch springs which are operated from the foot of the bed by a detachable crank, which controls a worm gear. An upholstered, leather-covered, adjustable reclining chair is placed in each room. In addition, rolling chairs are provided for all convalescents. Two smaller chairs in each room are fitted with cushioned glides to reduce the noise of their contact with the terrazzo floor. Every room is provided with a three-speed electric fan, fastened to the wall at a distance of about nine feet from the normal position of the head of the bed. A wash basin, fitted with an elbow acting mixing valve, has been installed in each room.

The combination metal cabinet used in this building is a new idea. It is divided into four sections, is mounted on an eight inch sanitary base, and is built into the room flush with the plaster wall. One side of the cabinet consists of a full length clothes closet; the other side is divided into three sections, upper, middle and lower. The upper section, containing adjustable shelves, is designed to receive a completely equipped surgical dressing tray and a nurse's bedside tray or basket. The middle section, insulated with half-inch cork, is designed as a receptacle for a portable refrigerator; the latter is constructed of wood with brass trimmings and metal mounting. The lowermost closet is designed for bed utensils; the door of this lowermost section is perforated, and the rear of the closet opens into an exhaust ventilating duct.

Artificial illumination in patients' rooms is obtained from three sources: there is, first of all, a center fixture with an extremely soft alabaster shade; second, a bracket with a soft colored shade and a graduated dimmer; and third, an adjustable reading light, attached to the head of the bed.

Patients' rooms vary slightly in size, the smallest being 10'9" x 15', and the largest 12'6" x 16'.

A double silent signal system has been installed, one color for nurses, the other for orderlies. Connected with this system are annunciators in the chart rooms and orderlies' stations, respectively. A megaphone type of annunciator is used for calling doctors.

The fixtures in the main kitchen are either built up on sanitary pedestals or are mounted on specially modeled monel metal feet. Kitchen odors are removed by exhaust ventilating fans, with a separate flue for the range hood.

The operating rooms have an individual exhaust system, with remote control for the motors. The vacuum and compressed air machines which are connected to all operating rooms are controlled by push buttons in the operating rooms. Instrument sterilizers in the operating rooms have been placed in metal lined recesses, which have sliding sash half way down the front, and exhaust ducts at their upper extremities. Ordinarily the operating rooms will be warmed by the house hot-water system, the screened warmed air entering through ducts; this system is thermostatically controlled. Supplementary or emergency heating is obtained by means of local steam coils, with hand valve control.

Main corridor and doors to patients' rooms.

It has been the endeavor in designing this building to secure throughout a cheerful effect of light and cleanliness and at the same time pleasant, delicate color.

The main entrance vestibule is lined with Verdella marble, the ceiling is vaulted and a general air of hospitality and cheer is obtained by the use of soft rich colors and large arched curtained windows. The reception room and parlor for the use of visitors which have a certain amount of simple decoration are comfortably furnished and present no suggestion of a hospital.

We are indebted to Messrs. Tenney and Ohmes, heating and ventilating engineers; Charles E. Knox Associates, electrical engineers; and Mr. Albert L. Webster, consulting sanitary engineer, for assistance in the development of the plans.

MEDICAL SERVICE WHICH A STATE HOSPITAL SHOULD PROVIDE

By A. L. BOWEN, Former Superintendent of Charities, Illinois Department of Public Welfare, Springfield.

"Each state hospital owes to its patients complete medical service," says Mr. A. L. Bowen in the accompanying article. "A state hospital medical service to be complete must be prepared to give each patient both on his arrival and at frequent intervals during his stay every possible advantage that he could get in the very best private general hospital; everything, indeed, that will help to place him in first class condition physically and to adjust himself mentally to his environment, so that he may resume within his limitations the pursuit of occupation, recreation and the pleasures of life. These privileges will render his stay in the institution serviceable to it and to himself."

AMONG the essentials of an institutional village or community of 2,500 or 3,000 persons is medical service. I have in mind in this connection what we know as the state hospital.

Of what should the medical service of a state hospital consist? How may it be organized? What results can be expected from such a service and organization as I shall describe?

In discussing these questions I remember that I am a layman and I confine myself to what a layman, after an experience such as mine has been, must conclude are the needs of the class. Consequently I write from the viewpoint of the patient and employe of this institution. Each question will be answered in a separate article.

A state hospital or state community of 3,000 so-called insane men and women will have a civil roll of at least 450 to whom the state is bound to give medical attention in all its branches.

Among these 3,450 people will be found every known and some unknown physical diseases and pathological complications. There are ever present all the problems of sanitation and public health. In addition to this fact, the institution medical service is called upon to treat all mental and nervous disorders, many of which are comparatively unknown or very slightly known by the general practitioner in the normal community.

The medical service of the state hospital must be even more skillful than that on the outside, for it must discover, detect and prescribe on a diagnosis in the formation of which it gets little or no information from the patient, possibly information that may be misleading or wholly false.

It is a wrong impression that psychiatry and neurology are the only medical specialties in such an institution. But they are important enough to justify me in placing them first in this discussion. This service should consist of not less than six men and women in an institution of 3,000 inmate population. The corps must be gauged largely by the activity of the reception service. Six is the irreducible minimum.

Preferably these officers should be of rather recent graduation. Only those keen and alive to the possibilities of research in this field and ambitious to reach the top in their profession can be tolerated. No administrative duties whatsoever should be imposed on them; they should be kept diligently and intensively employed in psychiatry and neurology.

The chances are that the normal community surrounding the institution is without such specialists. It becomes the state's duty in that event to detail its experts to assist the local general practitioner in all cases indicating mental or nervous disturbance. For the geographical district in which the institution is located the state's psychiatrists and neurologists should be available at all times for consultation and for the dissemination of knowledge respecting nervous and mental affections to both the profession and the general public. The state hospital then becomes a center in mental hygiene propaganda. The state can well afford to offer free of charge men in this capacity for this very vital object.

Every institution of this class requires an unusual type of doctor of internal medicine. As I have indicated diagnosis of physical disease is very much more difficult here than in a normal community. Many mental patients imagine they are suffering from physical ailments. The skillful physician can do much to remove them, whether they are real or fancied.

Dementia praecox types do not talk about their aches and pains, even when they recognize them as such. Undoubtedly they are constant sufferers from physical afflictions of many kinds. In the minds of some students, the praecox patient is a chronic sufferer from gastro-intestinal disturbances. To these patients and to many others, medical attention is due and should be applied. The physician with the right attitude does not wait to be asked or told. He learns to read symptoms

among these patients by intuition, by signs and by indications of which the general practitioner outside knows nothing. He proceeds to the performance of a humane duty. He never is satisfied to pass through the wards every day and to depend upon the attendants to report to him that "something seems to be wrong with Bill Jones this morning." Perhaps Bill Jones is dying and has been dying for days. This physician's duty is to detect sickness before the attendant senses something wrong.

The field for the specialist in eye, ear, nose and throat is rich and unlimited. I have known patients classed as dangerous and violent who became quiet and orderly when their eyes were corrected so that they could see clearly about them and read papers and books. I have known deaf patients who reacted violently to hallucinations which minor surgical operations and skillful treatment of the ear removed. One of the refined cruelties of modern state hospitals is their neglect of the eyes and ears of patients. Men and women request glasses and are put off on the specious plea that the state has made no provision to buy them. Adenoids and tonsils are present in nearly all insane patients. Every evil that these can inflict upon the normal being are inflicted in double force upon the insane.

Surgery Improves Morale of Institution

Surgery, I regard as of the very greatest importance. I know that many heads of state hospitals consider it very lightly and do not practice it.

Not many state hospitals are able by personnel or equipment to do major surgery. Yet my experience has demonstrated conclusively that the institution which cares for its major surgery and does it well has performed not only a humane duty to its wards but has improved the morale and good order among them and thereby relieved administration of some onerous problems. No sane reason has ever been given why an insane man should be compelled to carry about with him a heavy, irritating hernia while the sane man is freed from this physical burden by comparatively easy operation. The sane man is irritated by its presence and reacts in all his relations abnormally because of it. What must be its effect upon the mind already distraught?

In one institution with which I am acquainted as many as 250 major surgical operations are performed on patients every year with scarcely a single ill effect. Two mornings each week are devoted to this practice. The members of the medical staff have become intensely interested and from it have graduated into good private practice several efficient and well trained surgeons. The nurses' training school has been highly stimulated by the surgical experience and many have joined the classes because it was available. The operator in chief is the superintendent. He has had all that a modern surgeon requires. He keeps himself in tune by a three weeks' visit to the Mayo clinics and hospitals each year.

I can testify to the good influence of this service upon the general behavior of the institution. Patients are pleased to be relieved and show their gratitude afterward. Their relatives and friends whose consent is always secured in advance become warm supporters of the institution, believing it is sincerely trying to help its inmates.

No employe suffering from an operable cause would consider going outside, so great is his confidence in the institution's surgery. Among both patients and employes the hospital service, including the surgery has had an excellent effect. All through the range of operable diseases among both men and women the state hospital has a field and a duty that it cannot afford to neglect.

A specialist in the diseases of women is essential to a complete staff. There is no medical or surgical service so productive of relief and good results as that which the well educated and trained specialist in women's diseases can give.

I might continue the enumeration but it is unnecessary. The medical staff is not doing its duty and is not getting the results that are possible in such an institution when it fails to provide modern care and treatment in every branch of medicine. I firmly believe that each staff should have competent specialists in every field. As I shall attempt to show in a subsequent article such service has a high economic value.

Dentistry Service Must be Adequate

The medical service is not complete without adequate dentistry. Few state hospitals can boast of it. Many can only report none at all. One resident dentist is generally considered sufficient. These men have been poorly paid. There has been no incentive for them to work. To expect one man to care for all the dentistry among 3,000 insane patients, every one of whom needs care and treatment, is absurd on its face. My conception of dentistry in a state hospital is a staff large enough to give each patient a careful going over at least once each six months. Dentists should be given the standing and position of medical men and treated as a part of the medical staff. In this day, when so much stress is placed upon the teeth as origin of toxins which affect the mental and nervous mechanism, the very best dental talent possible to secure should be assigned

to the state hospital. Do not overlook the fact that these patients are not often accorded the privileges of the tooth brush. Mouths become extremely filthy through years of inattention and neglect.

The medical service must have its laboratories. Ability to do the routine work is sufficient if there is a central laboratory in the state to take care of the more important and highly technical work. Among them should be a psychological laboratory. The staff of such an institution requires one or more psychologists. They can be wonderfully valuable both in mental diagnoses and in subsequent placement of the patient in training and occupation.

Thus it must be apparent to my readers that a state hospital medical service to be complete must be prepared to give each patient both on his arrival and at frequent intervals during his stay every possible advantage that he could get in the very best private general hospital; everything, indeed, that will help to place him in first class condition physically and to adjust himself mentally to his environment, so that he may resume, within his limitations, the pursuit of occupation, recreation and the pleasures of life. These will render his stay in the institution serviceable to it and to himself.

How this medical service may be organized and put to work will be the subject of my next article.

ONE DOLLAR PER EMPLOYE PLAN AT BROAD STREET HOSPITAL

By WILLIAM HAMLIN CHILDS, Treasurer, The Downtown Hospital Association, New York.

Broad Street Hospital, New York, is one of the new hospitals of the Greater City. Less than five years ago it was started by Dr. A. J. Barker Savage to meet the need of downtown New York's great daily working population. The hospital was begun with a thirty-five bed outfit, without endowment and entirely dependent upon the support it could secure through efficiently meeting the call for general hospital accommodation. Today the hospital has ambulance service, registered training school, dispensary, a complete electro-therapeutic department, one of the most complete x-ray pathological laboratories in the United States, general hospital service with ward, semi-private and private rooms, and beds totaling 185.

Its contributions for building and equipment have been generous but have been used for this purpose only, and having no endowment the annual deficit for running expenses has had to be met by funds raised in the district by the usual methods of solicitation. After the building campaign in the fall of 1921, (which added a 100-bed eleven-story addition), the finance committee was face to face with the task of raising approximately $100,000 to meet the deficit in current expenses. To secure that amount in the district after the campaign seemed like a large order, and it was suggested to the finance committee that each employer in the district be asked to contribute toward the funds of the hospital a donation equal to a dollar per year for each employe in his service. This plan met with their approval.

The district was divided up according to business and professions, such as chemical, shipping, banking, law, etc., a chairman being appointed for each division.

A circular was printed as follows:

"This is your Hospital—owned by you—managed by your representatives—for the instant service and benefit of yourselves, your employes and the poor people who are your neighbors. In equipment and standing it is not excelled by any other hospital in the city. It is yours and should be your pride. To maintain this standard and to render the largely increased service demanded by its enlarged facilities requires a maintenance fund of approximately $100,000 per year. We have put this upon a strictly equitable business basis and ask from each concern one dollar per employe per year, with a minimum of $25.00 for less than twenty-five employes. Kindly sign the detach pledge on back of last page, and give to bearer or mail. Bill will be rendered to you by treasurer."

A pledge card was attached to the circular and a statement showing what the hospital had accomplished in the past year.

The method of bringing the idea to various boards of directors has been of great value in making known the hospital and its work. For instance, the board of governors of the Stock Exchange, which has its headquarters in the district served by the hospital considered at one of its meetings the matter of including their hundred employes in the plan, and they unanimously agreed to do so. Likewise the action of board of arrangements of the Stock Exchange, which represents the hundreds of firms listed on the Stock Exchange, and that of the Merchants' Association of New York in endorsing the idea and enrolling their own employes gives a prestige and standing in the eyes of the firms and corporations in the district hardly obtainable by any other method. Not only does this mean financial support but it means a knowledge of, and interest in, the work of the institution by many representative men which otherwise would be difficult to secure.

One great point is that in the future the hospital will have a group of backers which can be depended upon to take care of the deficit incurred and thus leave the finance committee free to center its work on an endowment and extension fund to keep pace with the growing requirements of the hospital.

The one dollar gives no special privilege or service to anyone; it only insures to the employer that a thoroughly equipped hospital is at hand and he is paying his prorata of cost so that he can be assured of hospital service for his employes at any time needed. As a matter of duty to his less fortunate neighbors the hospital performs a great deal of free work and the employer is helping to pay for that, but the idea kept to the fore is that the dollar per year is in the nature of insurance of hospital accommodations in a district that previously was without that service.

Quite impossible condition for a superintendent was that after being asked to go a long distance to finish the building of a hospital, furnish, equip, and organize a training school, and after the superintendent found that the chief surgeon's office nurse, going with him for operations, had more to say in the management of the hospital than the superintendent herself. The board of managers allowed this condition to continue with the result that they soon lost their good, conscientious, and active superintendent.

THE CARE AND DISTRIBUTION OF LINEN IN A TYPICAL SMALL HOSPITAL

By LILLIAN MARSH, Superintendent, Mary Frances Skiff Memorial Hospital, Newton, Iowa.

THE care of linen in the hospital is a problem which requires careful consideration. It is essential that all persons who handle the linen know something of initial cost, and thus be enabled to appreciate the necessity of preserving it in every way possible. If proper instruction along this line is given to nurses, as well as employes, much damage due to carelessness may be avoided.

Hospital superintendents, as a rule, are prone to lay a great deal of blame for the destruction of linen to the laundry department, but much may be said concerning the care of linen before it is sent to the laundry.

It is a lamentable fact that a large amount of the repair work on sheets and counterpanes is due to carelessness in the hospital proper. In the nurse's haste, too often the sheet is simply thrown on the chair. Perhaps the hanging corners are caught by the bed as it is moved about, so that they are torn or at least badly soiled. The result is added work in the laundry and a weakening of the fabric which has only a short life at best.

Many times we find that nurses fail to fold the linen as it is removed from the patient's bed. In this way pieces which might be used the second time are soiled and crumpled and rendered unfit for use until laundered. Nurses should be impressed with the reasons for the routine of bed-making and should be convinced that the method, as taught, not only saves time, but also safeguards the linen.

Route Taken by Linen

Let us now follow the various processes in the handling of the linen from the time it leaves the patient's bed until it is ready to be returned.

From the patient's room the linen is carried to a chute or hamper. If the hospital boasts of the former, it is fortunate to have a sanitary chute made of glass or a non-corrodable metal. If the chute is not of this type it should be watched carefully, for injury to linen as a result of abrasion, due to a rough surface or splinters, is frequent. In many institutions, as in our own, the chute is dispensed with on account of the expense of its construction, and hampers only are used. These are placed in the utility rooms. Hamper bags are collected several times a day and transferred by truck to the laundry. Here a platform of smooth surface should be provided for the deposit of the linen. Never place it on the floor, for many articles are ruined by being trod upon by sharp edged or nail-projecting shoe heels of the workers. Much injury to linen may result from the practice of tying the laundry in sheets and allowing these bundles to be dragged over the floor.

When the linen is taken from the patient's room it is sorted by the nurse in the utility room. Any soiled articles which require rinsing are placed in the hopper for this purpose. Latter they are given the attention necessary by the floor maid. Likewise the linen from infectious cases is placed in receptacles for the purpose and disinfected before being taken to the laundry. In the contagious department the disinfecting of linen is taken care of by the nurse. It is either placed in a disinfecting solution or sterilized by boiling. It might be added here that if an electric wringer is placed in the utility room of this department, it will facilitate the nurse's work considerably.

Simple Formulas for Removing Stains

Another duty which may not be overlooked is the removal of stains. If the nurse is in doubt as to the character of the stain she should consult an authority. Failure to do so may mean a stain is permanently fixed and an article otherwise good must then be discarded. A few simple formulas follow:

Blood stains, if fresh, may be removed by simply washing in soap and water, or by soaking in cool normal salt solution. For old stains the same method may be followed, allowing them to soak for a longer period. If this is not effective javelle water may be used.

Bichloride of mercury: soak in Labarraque's solution, wash and rinse as soon as the stain disappears.

Iodine: apply cold starch mixed to a consistency of paste with ammonia water.

Iron rust: use a solution of oxalic acid, rinse thoroughly as soon as spot is removed as the acid will eat holes in the linen in a short time.

Silver nitrate: These stains may be permanently removed by using a solution of potassium iodide; care must be taken that the solution is thoroughly rinsed from the fabric.

Oil: wash in soap and warm water; ether will assist greatly in cutting the oil but this is not practical if the spots are large.

Potassium permanganate: apply a weak solution of chlorinate of soda.

It is well to keep a list of formulas for the removal of ordinary stains posted in a conspicuous place, for the ready reference of the maid in charge of the table and tray linen. Unless she has something in the way of a gentle reminder she is liable to become negligent, or perhaps use a solution which may cause an indelible stain. The most common stains in this department are tea and coffee, with or without cream, which may be removed by washing, first in cold water, then by placing in boiling water. For berry stains place spot over basin and pour boiling water through. If the stain does not disappear repeat the process. Pear, peach, and plum stains are of a similar nature: wash the article in warm water in which a little soda has been dissolved.

As a further precaution in the preservation of linen, samples are taken at frequent intervals of the rinse water, fabrics direct from the laundry extractor, and deposits from the washing machine. These samples are sent to the laboratory, where chemical and bacteriological tests are made. By this means one is able to ascertain whether the linen is thoroughly sterilized, whether the washing machines may be carriers of infection, and whether the chemicals which are used have been properly removed from the fabric. Alkali left in the goods may do a great deal of harm. It is an excess of acids which causes small holes and weakens the tensile strength.

In regard to the distribution of linen, the following method is one which in our hospital we have found to be both simple and satisfactory:

The soiled linen, as before stated, is gathered from the utility room by the janitor and taken to the wash room in the laundry. When laundered it is placed at once upon the sorting shelves. Here it is divided into respective classes, and a list sent daily to the office so that the yearly amount of laundry may be estimated.

A requisition is made out daily by the head nurse on each floor for the amount of linen required for that day. The maid calls for this list at a stated time in the morning. She counts out the required amount and places it in carriers to be transferred to the various floors. Here the head nurse delivers it to the respective nurses for use in the wards. After this distribution there is necessarily a surplus. This is left on the shelves in the sorting room. Formerly we divided the surplus between the various floors and placed it in the linen rooms. However, experience has taught us that it saves considerable time to leave it on the shelves. In case of emergency, or on holidays, the key is available and the linen can be obtained without loss of time.

When the linen is sorted it is carefully examined for holes, tears and worn spots. All defective pieces are sent to the sewing room to be repaired by the laundry maid, whose duties are to check, sort, count, mark and mend all the linen. Usually her time is not entirely consumed by the foregoing, and the reminder may be used to good advantage in making up linen supplies. A list is made monthly of all condemned articles which have been replaced by new ones. By so doing we endeavor to keep practically the same amount of linen in use continuously.

The condemned articles are carefully examined, and any parts which can be used for other purposes are put to the best use possible. Large sheets are made over into draw sheets, small sheets for a child's bed, bassinets or small pillow cases. Likewise counterpanes may be utilized for the children's ward or made into attractive dresser covers for the wards. Worn and patched linen is used as much as possible in the isolation department as the daily disinfecting and sterilizing are more or less injurious to the fiber.

An inventory of all linen is made semi-monthly by the maid. This is not as great a task as it might appear to be. All soiled linen which comes to the laundry too late to be washed that day is counted, as well as the remaining clean laundry on the shelves. On these days each nurse sends to the laundry department a list of the linen in use in her department. The sum of all these gives us the correct amount on hand. In this manner we are better able to keep track of our supply.

It should be mentioned that all linen, with the exception of that in use in the contagious department, is marked with the hospital name only. We mark the center as well as the hems to prevent an occasional unscrupulous employe from appropriating it for personal use. The best indelible ink procurable should be used for this purpose. If this is done and directions carefully followed, remarking will rarely be necessary.

With the cooperation of nurses and employes a system of this kind may be easily followed, and in most cases we believe the results will be very gratifying.

CANCER WEEK IN NOVEMBER

National Cancer Week for 1922 will be conducted during the week beginning November 12, according to a recent decision of the executive committee of the American Society for the Control of Cancer. State and local committees, of which there are now more than 650, in cooperation with officials and volunteer agencies will aid the national organization in putting on the educational campaign.

Last year the American Society for the Control of Cancer inaugurated National Cancer Week for extending to the public the known facts concerning cancer control. The 1922 campaign is expected to be much wider in its scope.

SUPERINTENDENTS' REPORTS TO THEIR BOARDS OF TRUSTEES

By S. G. DAVIDSON, Superintendent, Rockford Hospital, Rockford, Ill.

IN ORDER to develop hospital administration it is essential that the board of trustees be fully informed regarding the operation of their hospital. Only through reports rendered by the superintendent can the board intelligently measure the service being rendered the community.

Board meetings are generally confined to the discussion of a stereotyped monthly financial report and to such criticisms as may be heard in the course of idle town gossip. Usually the superintendent is put on the defensive or the board meetings deteriorate into a social gathering. There is no reason why the superintendent of the hospital, presupposed to have a greater knowledge of hospital administration than any board member, ought not to educate and lead his board into a larger field of hospital administration. Lack of definite knowledge as to how this may be accomplished is perhaps the reason why there has been such laxity in developing our hospitals or in educating our boards of trustees to the basic reason for hospitals, namely, medical service to the sick.

The superintendent who can get his board of trustees to dispense with the discussion of petty complaints and carping criticism around which their meetings are prone to center, who can lead them away for a short time from the business administration to the other angle of hospital administration which bears on the medical service given, will find himself known as one of the real hospital administrators. Furthermore, he will secure for the people of the community in which his hospital is located a medical service such as has never before been thought possible. The day of the old type of superintendent is passing and in his place is coming one who may rightly be called an expert.

It must be clearly understood that there are two sides to hospital administration. First, the hospital should provide a place where the best medical service can be given, and where every possible facility is at hand for diagnosis and treatment, and second, it should have a business administration to secure its finances, supervise their economical expenditure and maintain its equipment. Recently there has been considerable discussion regarding the kind of report which should be made by the superintendent to the board of trustees at their monthly meetings. Because the superintendent is, or should be, the general manager of this business and because the board of trustees are directors of the business, it is to be supposed they desire as complete a report of it as they would of any other business in which they might be directors. They are not, or ought not to be, interested in the isolated complaint of whether or not Mrs. Jones received cold toast yesterday morning or whether or not Mr. Brown had sufficient blankets while he was a patient in the hospital, but rather are they concerned about the answers to such questions as "What kind of medical service did Mr. Brown or Mrs. Jones receive?" "Did Mrs. Jones die, and why?" "Was it the fault of her attending physician?" "How often does he have such cases as these and what are his results?" "Did Mr. Brown's physician have any laboratory tests performed for Mr. Brown while he was a patient, and if not, why not?" "How often does Mr. Brown's physician use the laboratory; why does he not use it more?" "How many of our men have consultations on their cases, and why do they not have more?"

The superintendent who can get his board of trustees to ask for such facts as these and who can lead them away from the business administration for a short time to this other angle of hospital administration will find himself known as one of the real hospital administrators. Furthermore, he will secure for the people of the community in which his hospital is located a medical service such as has never before been thought possible. For while members of the board of trustees may not be interested or may not know anything about an operation for gall-bladder or appendicitis, they will be mightily interested in knowing how many gall-bladder cases die and how many appendicitis cases die; which physicians on their staff are successful in these operations and which are not. And too, they will be mightily interested in the facts presented to them of how many unnecessary operations are performed. Until superintendents begin to do these things, we shall not get very far even with the help the American Hospital Association can give us, excepting in this respect that the Association is educating the board of trustees, and the time is coming when the superintendent who does not

furnish this information is going to pass out and in his place is coming the expert efficiency superintendent, who overlooks no angle of good hospital administration.

Value of Standing Committees

Of course, the ideal way of securing this interest on the part of the board of trustees is to have the board divided into standing committees, composed of three men each. These committees might be building and repairs; finance, nursing, medical and social service. The chairman of each committee, together with the president of the board and the superintendent of the hospital, should constitute the executive committee. These committees are sufficient to cover every phase of hospital activity and should meet regularly, at least once each month and oftener if necessary. The executive committee should meet regularly each month, and the chairmen of these sub-committees, being members of the executive committee, should report all the activities of the hospital under the supervision of their particular committee; these reports should be supplemented by detailed information from the superintendent.

The order of business for an executive committee such as outlined here should be as follows:

Reading minutes of previous meeting.

Reports of standing committees.

Reports of special committees.

Report of the superintendent on what he has done in carrying out programs as determined in the various standing committee meetings.

Unfinished business.

New business.

The superintendent may make a report, for which he desires the sanction of the entire executive committee on any plans for development which he may have worked out.

The report of the executive committee, made at the quarterly meeting to the board of trustees is a formal matter, being given for the purpose of securing adoption by the whole board.

Superintendent Should Make Reports

While this is an excellent and ideal organization, it may not work out readily in all hospitals, especially in the beginning of any reorganization plan, because of the lack of interest which may exist on the part of members of the boards. In the beginning, it may be necessary for the superintendents to make detailed reports regarding the operation of each department to the board of trustees at each monthly meeting. In order that there may be a basis for comparison, these reports should be prepared on standard forms; this would also eliminate the opportunity for the superintendent to overlook making reports on any particular phase of hospital work. Such reports might be multigraphed and copies furnished to each member of the board of trustees. A minimum of information to be given the board of trustees or the executive follows:

Date. Number of patients in hospital: pay, part pay, and charity; number, admitted since last report; number discharged since last report; number discharged, cured, improved, dead; causes of death. Number of patients according to doctors, pay, part pay, and charity. Names of doctors whose patients died. Conditions of records for each doctor for the month. Amount of laboratory service ordered by each doctor for each patient during month. Amount of x-ray service ordered by each doctor for each patient during the month. Report from dietitian regarding the cooperation of physicians in using this department of hospital service for the treatment of patients. Any other diagnostic facilities and how often used by the attending men. Amount of work performed by the laboratory. Monthly statement of finances, including business put on books, money taken in, accounts payable, cost of operation per diem per patient, funds available for operating expenses, and inventory. Condition of x-ray. Condition of laboratory. Condition of training school. Condition of medical service. Condition of dietary department. Condition of heating plant. Physical condition of plant. Outline of accomplishments. Outline of work planned for the ensuing month. Outline of improvements and developments. Sanction of board of trustees on work accomplished and for new work to be undertaken.

This will cover the reports of work performed in the average hospital. However, where there is a social service department, where follow-up work is being carried on, or where there are any other departments not mentioned in the foregoing, as complete reports should be made of the accomplishments of these departments as has been indicated above. With such information submitted to them each month, there can be no question but that boards of trustees will very quickly develop a more intelligent interest in the better practice of medicine in their hospitals and a consequent better development of their institution.

Major Chris M. Sampson, now located at the U. S. Marine Hospital No. 70 in the New York, personally took 7,000 feet of film at the Public Health Hospital formerly at Fox Hills, Staten Island. The film, which is being exhibited at various conventions, illustrates the physiotherapy work done in his department for wounded soldiers where as many as 50,000 treatments were given in a single month.

Do not try to produce an ideal child; it would find no fitness in this world.—Robert Spencer.

A HOSPITAL AS A HOTEL FOR THE SICK

By DAVID HADDEN, M.D., Oakland, Cal.

To take an individual from the privacy of his home and to subject him to all the disagreeable factors of sickness in a hospital is to Dr. Hadden a degrading procedure. It is the hospital's obligation, he declares, to supply the patient with the service he would demand at a modern hotel. Instead it is boarding house service that is most apt to be the patient's lot in the hospital of today. The sick man must take the food brought on his tray and must share his bathroom with other boarder-patients. Dr. Hadden advocates the complete segregation of charity and pay patients so that the latter may pay only for the service they themselves receive. For persons of moderate means he urges a loan fund.

IN A previous article published in THE MODERN HOSPITAL* I made the statement that the modern hospital should be a hotel for the sick. Shortly afterward in an address dealing with problems of public service, one of our prominent hospital experts is quoted as saying: "A hospital is not a hotel or boarding house for the sick." In my mind there is no doubt but that this gentleman has just as elevated ideals for the future hospital as I have, and the discrepancy arises because the nomenclature we are using conveys to each of us a different meaning.

In its original use the word *hospital*, was applied to those places devoted to the shelter and entertainment of transients and strangers, and principally to those houses providing free service. Later the word came to be applied to institutions that cared for the helpless, needy and old, at public expense or through endowment. Gradually this type of institution, still at public expense, began to care for the sick and injured, and it is only in later years that paying guests were added to help bear the burden of free entertainment.

Consequently the word *hospital* conveys to the general public a picture of what our almshouses and county hospitals are at the present time, institutions that care for charity patients only.

Bond Houses Will Not Finance Hospitals

The charity phase of present day hospital activities has been so emphasized through public fund campaigns, bazaars, raffles and even horse racing that the average individual has not yet learned to associate any other manner of caring for the sick with this idea of a charity or semi-charity institution. In fact business men as a whole have a well rooted idea that hospitals are poor investments. No bond house will as yet finance bonds for hospital construction even when the interest is guaranteed, though hotels and apartment houses are now considered safe for bond issues.

We all know that a few years ago it was well nigh impossible to persuade many a patient to enter a hospital because of the charity stigma and of the idea that the hospital was a place of last resort, only to be sought when the need of operation or lost hope of cure compelled entry. How well we all remember the common exclamation, "Why, Doctor, that means there is no hope for me!" when we advocated the patient's removal from home. Even now so many of our hospitals are semi-charity institutions that we find patients who object to enter them for fear some friends may think them objects of charity. In England we find the term "nursing home" used to distinguish a pay home for the sick from a charity institution.

Semi-Charity Hospitals Boarding Houses

The term Boarding House was applied and still has reference to the private or semi-private home where outsiders are taken in to sit regularly at the family table as a method of adding to the householder's income. This is really the state of affairs in the majority of our present day hospitals. We can consider the free patients as members of the family who contribute nothing, and our paying patients as the boarders whose presence help meet the running expenses of the home.

In fact this is the phase that exists in every semi-charity hospital. The pay patient's rooms are carrying an overhead to provide for the free or low priced beds. Is it just to saddle upon persons who can pay for service an overhead that really compels them to donate to charities? Yet this is the condition that in many cases now exists.

I believe that we should segregate our pay institutions from our charity ones. We should make our charity institutions out and out such, and conduct them through our municipal, county, state and national bodies or through endowments. Then when we have eliminated all strictly charity work from our pay institutions, we can give high grade service at a more reasonable figure to the

*Vol. xvi, p. 414.

vastly greater numbers able and willing to pay a fair charge for hospital care. I believe in such an institution the cost of service can be so figured that the patient can be cared for at cost, plus a fair profit, say 10 per cent; hospital charges can thus be reduced to serve that class which has only moderate means; and yet the institution can be made to show a profit on the investment. No individual who spends a vacation at a country hotel or stops for a period at a boarding house expects the proprietor of that hostelry to serve him without a fair profit, and so it should be with our modern private, if you like to call it such, hospital.

Should Provide Part-Pay Institutions

There should also be in our charity hospital field a place for an institution that has some provision for patients who can only pay a partial charge. No individual should ever be the subject of charity who can return in money or labor any degree of recompense. Even the $100 per month income that is used by some institutions as a gauge for determining whether a patient shall receive free service is illogical and pauperizing. One hundred dollars per month as an income in one family may give some opportunity for savings, whereas members of another family of the same size with poor business judgment and extravagant habits may be starving themselves with an income of twice that amount.

On the other hand the terms "inn" and "hotel," though the establishment known as a hotel is considered a hostelry of higher standard and pretentiousness than the inn, are institutions designed to care for and entertain strangers and transients who can afford and expect to pay in proportion for whatever grade of service they receive. This is just what our hospitals that are not charity institutions should be to our sick and injured, who are in a sense transients compelled to be away from home.

The speaker who stated that a hospital must not be a hotel or boarding house for the sick, I believe is desirous of conveying to his hearers the idea that in the modern hospital we have not an institution to which any individual may obtain admission if his condition or his professional attendants do not conform to the institution's rules and standards. However, does not a modern hotel do just this same thing? An unwelcome guest is politely told to seek housing elsewhere and goes without question.

Insurance Companies Should Pay Full Rate

It will not be amiss to consider the industrial insurance question as it relates to hospital charges. It is very evident that our accident insurance or sick benefit corporations have the habit of expecting a hospital to carry its beneficiaries in beds priced at less than their actual cost to the institution. They, too, seem to entertain the idea that because their business is more or less continuous they should get discounts on hospital adjuncts, such as x-ray and operating room service, which creates a double priced standard of service. These corporations probably get equally good service but do they get equally as good professional attention in applying the discount method to their physicians and surgeons? The human element enters largely in such instances; usually we get only what we pay for and the return is graded accordingly. Why an insurance company should accept semi-charity, again at the hands of the higher priced room occupant, I fail to see.

"Mixed Hospitals" Are Subject to Criticism

The modern private or corporation owned hospital is in every fact a hotel where the individual who needs housing and care when ill can obtain all the comforts and necessities that one demands in a hotel plus those further requirements necessitated by illness; a hospital where such service can be offered at a moderate rate commensurate with the character of service rendered but in no case at less than a charge which permits the operators to conduct the business at a profit.

This entails naturally the separation of our charity cases from those able to pay their own way. This segregation in no way lessens the duty of the public toward our worthy sick and unfortunate, but would do away with a lot of public questioning as to whether donations are not in reality permitting the operators to make greater profits from the paying patients.

When a mixed hospital, meaning thereby an institution taking free and pay patients, is part of a medical college there is a far greater chance of criticism. An illustration may best convey my meaning. A man with an obscure pathology was sent for diagnosis by his physician to a state medical college hospital. The man was penniless and deserved free attention. His stepson, a man well able to pay his way, was later accepted by the hospital without reference by any physician as presumably of the same financial condition as his stepfather; he was operated upon free of charge and given hospital care. This was unjust to the taxpayers of the state. By paying nothing to the staff for operation he also was doing an injustice to the medical profession.

I agree that excessive profits taken by hospitals are unfair and even unjust but excessive profits in any other line except the speculative ones are also wrong. A fair profit on the other hand is a factor that encourages better service and more cheerful labor.

It has been said and rightly so, that the two classes which get the best hospital care are the rich and poor, and that the greater class of those in moderate circumstances often cannot afford to pay what is asked, and their pride will not permit them to accept charity. Of course, many persons able to pay make every effort to get free service but the vast majority are above stooping to deception. It is to these people that we can offer true philanthropy by establishing a loan fund.

There is a teacher, for instance, with a mother or child to support whose income is sufficient under normal conditions but who is handicapped by sickness. Every medical man can put his finger on individuals who are postponing operations or needed medical care until the money is in sight. How many physicians and surgeons have advanced the hospital charges to patients hard pressed and too sensitive to go to the charity institutions? What a godsend to such an individual if, from a hospital fund, could be borrowed the necessary money on a personal note without collateral at a low rate of interest. These loans could be paid in small payments over a long period, if necessary, and such a loan would protect the borrower's feelings and be a method of real philanthropy. The percentage of such loans unpaid would be almost negligible for the great middle class is inherently honest. How often I have wished for philanthropically inclined individuals who would place a fund in my hands for this purpose. This loan fund could best be handled by a bank as a trust fund and made available to the individual through the hospital.

Hospital Service Should Equal Hotel

Now to return to the consideration of the hotel aspect of a hospital. When we speak of hotels we at once conjure up a picture of a comfortable, modern, fireproof building, where we can find privacy and comfort in our room. We expect a private bath, hot and cold water, sufficient heat and the satisfaction of all our wants from mailing a parcel post package to obtaining toothpaste and clothing. In many hotels now the morning paper is under the door and breakfast may be served in bed. The dining room may offer you a club lunch at a fixed price but the menu is there that will meet all your whims.

On the other hand how many hotels for the sick or convalescent are there that give any choice of food outside of the boarding house type of tray or how many can provide a private bath. The majority of our hospitals are of boarding house type in more senses than one. I say let us get away from that type and offer our people hospitals that are real hotels.

I have only touched on the medical and nursing phase of this subject but there is no serious objection whatever to fitting in all our medical service ideals to the hotel idea.

Ward System Retards Patients' Progress

In this connection I want to protest against the ward method of caring for our patients. Personally, I am strongly opposed to any wards whatever. From the standpoint of the hospital and the physician a room with many beds is a failure. The disturbance of convalescent cases by the more serious ones retards recovery. The comparison by patients of their ailments, treatment, and care is not conducive to the best results. That an individual used to privacy in his own home should be subjected, when sick, to all the disagreeable factors of sickness in a hospital is to me a degrading procedure. A two-bed room is less objectionable if the patients are agreeable to each other. Such rooms permit of better segregation of patients than can be had in a ward. The one or two-bed room also increases the efficiency of the nurses, especially when toilet and other facilities are supplied for each room, for in a ward we increase the nurses' distance of travel and lessen efficiency.

Hospitals Have Advanced Rapidly

The primary relation in all things medical is that of physician to patient. The hospital was established as a cooperative arrangement among physicians by which a physician was able to offer better medicine to his patient with a greater degree of safety, if not at lesser cost than in the home. We have only to go back twenty-five or less years to recall that most operations were done in private homes. I can remember as a student going into the homes of the well-to-do to help set up an operating room with the aid of the kitchen table, after carpets and curtains had been removed and the floors and walls gone over with antiseptics. Also as a student I remember Nicholas Senn in San Francisco operating in the anatomy amphitheater on a dissecting table to show that we could secure the necessary degree of asepsis anywhere. In these twenty years our hospitals have developed from those that I have described to the efficient cooperative establishments of the present day, but there is still room for improvement.

I feel that the modern hospital must be in very fact a hotel for the sick, designed, built and operated to serve the physician and patient without interference in any degree with the relation upon which the successful practice of the art and science of healing depends, except by setting forth a standard that is high and points to progress.

The MODERN HOSPITAL

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COMMITTEE FORMULATES PLAN FOR EDUCATION OF NURSES

SUCH is the importance of the report of the committee on nursing education appointed three years ago by the Rockefeller Foundation that we print it in full as the leading article of this issue. Every hospital superintendent and the head of every nurses' training school should give it careful consideration.

The report is based on an exhaustive study made by Miss Josephine Goldmark. It covered not merely the work and proper training of public health nurses as contemplated when the committee was first appointed but the entire field occupied by the nurse, in order to determine the tasks that need to be performed, the qualifications necessary for their execution and the minimum educational standards of each type of nursing service for which there appears to be a vital social need.

The report calls attention to the obvious fact "that the public health movement has passed far beyond its earlier objectives of community sanitation and the control of the contact-born diseases by isolation and the use of sera and vaccines," and that the major health problems can be solved only through personal hygiene. These changes in the daily habits of people call for a type of education which is so personal in character that it can best be accomplished through the direct personal contact of the public health nurse with the conditions of the individual life. To accomplish this purpose in the United States 50,000 public health nurses are needed as against 11,000 now in the field. They should possess the fundamental education of the nurse supplemented by a graduate course in the special problems of public health. This supplementary course should of course also be taken by all nurses who expect to become nursing superintendents and supervisors.

For the rank and file of nurses who are needed to carry on the routine nursing service in our hospitals and homes incident to the care of persons suffering from serious and acute diseases, the committee feels that the standards of education now generally accepted should be maintained but that the length of time devoted to this training may wisely be reduced from three years to two years and four months, with an intensification of the educational content of the course which will raise rather than lower the actual, educational achievement.

For the routine care of patients suffering from mild or chronic diseases or in convalescence, as well as for assistance in certain phases of hospital and visiting nursing, the committee recommends the training of a subsidiary group to be known as nursing aides. Their functions should be defined by legislative act. They should be licensed to serve under practicing physicians and to assist under the direction of trained nurses. These aides, it is recommended, should be trained in special hospitals, in small unaffiliated general hospitals or in separate sections of hospitals where nurses are also trained. The course of study should be of eight or nine months duration provided the standards of such schools be approved by the same educational board which governs nurses' training schools.

One of the most significant sections of the report deals with the financial problem involved in carrying out this scheme of nursing education. "It is time," runs the report "that the hospital should be relieved from the dilemma of exploiting student nurses on the one hand, or of diverting funds given for the care of the sick on the other hand, by the provision of endowment specifically devoted to the purposes of education."

The committee closes its report with the recommendation that the development of nursing service adequate for the care of the sick and for the conduct of the modern public health campaign demands as an absolute prerequisite the securing of funds for the endowment of nursing education of

all types; and that it is of primary importance in this connection to provide reasonably generous endowment for university schools of nursing.

WHO PAYS THE BILL?

ROUGH estimates on the exposition of equipment and supplies to be held at the American Hospital Association convention at Atlantic City easily place the cost at $100,000. This figure includes the rentals for space, the salaries, railroad fares, hotel charges and traveling expenses of the representatives of the firms exhibiting, and the freight, cartage and packing of exhibits.

A common impression is that this enormous outlay is borne wholly by the exhibitors, but we believe that in the final analysis it will be found that this expense is borne by the hospitals of the United States and Canada, whether or not they are members of the American Hospital Association. As a matter of sound business practice this expense must be made a part of the sales cost. An invitation to a manufacturer to place his product on exhibition at the annual convention is tantamount to an order from the American Hospital Association to set up an exhibit at a given place and time in order that it may be studied by the representatives of the hospitals in attendance at the convention.

If this be true, then these considerations follow. In the first place, it behooves the hospitals that are not members of the American Hospital Association and are helping to pay for the annual exposition to join the association and reap the benefit of this service. To stay out is to help pay for a service from which only others derive the benefit.

In the second place, it behooves all of the hospitals that are members of the association to send representatives to the convention to avail themselves to the greatest degree of the services the exposition offers.

Finally, it behooves the American Hospital Association so to organize its annual conferences as to give the delegates ample opportunity to inspect the exhibits. That an effort has been made in this direction is evidenced by the tentative program of the association recently issued. Not only will ample time be allowed both morning and afternoon for the delegates to visit the exposition, but five special committees have been appointed to give discriminating study to the different divisions of the exposition and to make reports at general sessions held early in the convention.

There is reason to feel that under this plan both delegates and exhibitors will have every opportunity to make the most of the exposition feature of the convention—the exhibitors to bring their products and service to the attention of the delegates, the delegates to acquaint themselves with the latest equipment and supplies for the efficient operation of their institution.

LUXURIOUS NURSES' HOMES ARE OF QUESTIONABLE BENEFIT

FROM reports that have come to our desk during the past six or eight months there has evidently been a pronounced addition to the number of hospitals that have built modern nurses' homes. By and large, this tendency is one of the encouraging tendencies of the times in the hospital field. All too often in the past the nurses have had to put up with deplorable housing conditions. But with the hospitals' greater need of nurses many institutions have come to see that one way to increase their enrollment is to provide nurses with adequate and comfortable housing facilities. This is as it should be and is most commendable.

We have, however, observed of late with some misgiving the construction of several nurses' homes, the equipment and appointments of which find their counterpart only in the residences of our wealthier citizens. We cannot help but wonder what the effect of three years of life in such luxurious surroundings will be on the future work and attitude of the students. Many of the girls come from a home environment which, though comfortable and refined, is far from luxurious; indeed, the homes of the wealthy are scarcely conducive to enlistment in the ranks of the nursing profession. Future calls to service will enable few who leave these homes to live in a similar environment, and it is pertinent to inquire whether three years of life in a luxuriously appointed nurses' home will make pupil nurses more or less willing to take up their appointed tasks in a less congenial environment.

A word as to another aspect of this question. If a hospital finds itself the fortunate possessor of funds which are considerably in excess of what is actually needed to build and equip a simple yet dignified nurses' home, would it not be well to place the surplus in an endowment fund devoted to the educational work of the school? This would be in keeping with one of the principal recommendations of the recently issued report of the committee on nursing education which emphasizes the imperative need of providing distinct and adequate financial backing for the nursing schools, if they are to function properly as educational institutions.

A DISGUISED FORM OF BRIBERY

TIME was, and that not so long ago, when commercial salesmen found it greatly to their advantage to keep purchasing agents of the concerns with which they sought to do business liberally supplied with presents. Firms that oftenest and most liberally crossed the palms of the purchasing agents stood the best chance of getting orders, notwithstanding the lower prices and, often, the better quality of the goods offered by competitors. Boxes of cigars, seats at the theater, tickets to a prize fight and a hundred and one other and more costly bribes were thrust into the hands of the purchasing agent in an effort to curry favor and obtain coveted orders.

But rare indeed and growing still rarer is the purchasing agent who today will accept even so much as a box of cigars from any salesman with whom he deals. The practice simply isn't countenanced in the best business circles. The up-to-date commercial concern knows that sound, substantial business cannot thrive on sentiment; it must be grounded on business principles.

Yet there are hospitals—institutions which, quite as much as purely commercial concerns, need to be run on sound business principles—that still invite a form of bribery by soliciting contributions from the firms with which they deal. They think thereby to increase their income, but they fail to see how contrary this practice is to the new spirit that pervades business and how it lays their institution open to unrecognized losses through inferior goods and higher prices. And the astonishing thing is that in so many instances the individual trustees of the hospital would not tolerate such practices in their own businesses for a moment.

If your institution is among this number, we urge you to drop the practice and align yourself definitely with the larger number of modern business concerns that have relegated it to the limbo of discredited methods of the past.

YALE HONORS MISS NUTTING

"ONE of the most useful women in the world"—thus did Professor William Lyons Phelps characterize M. Adelaide Nutting when he presented her for the degree of Master of Arts at the commencement exercises of Yale University, June 21, 1922. All over the length and breadth of this land the message that a great university has singled out their beloved leader for such honor gladdened the hearts of nurses, for it has been their high privilege to know and benefit by "her devotion, courage, faith, skill and magnificent perseverance."

Miss Nutting, the one woman among thirteen men so honored, is such a worthy representative of her sex that nurses are justified in being very proud that she is one of their professional sisters. But it is nothing new for them to be proud of Miss Nutting, for her vision and influence have been back of practically every progressive movement in nursing for the last thirty years, and she has had a large share in many other social, educational and public health movements, both local and national. The limitations of space forbid a recounting of all her worth-while contributions, but two must be mentioned, the two most significant movements in the nursing field today which are due in very large measure to her initiative and wise statesmanship. One is the survey of nursing education which has been made under the general direction of the Rockefeller Foundation, and the other is the endowment campaign of the Johns Hopkins Nursing School Alumnae which plans to secure the first endowment in this country for a school of nursing. She was the first to see that the great weakness in the present system of nursing education is its unsound economic foundation, and this effort to secure adequate financial support for one school is the beginning of a wider movement which promises to be the most fundamental reform in nursing in a generation.

Miss Nutting has a rare combination of qualities—a penetration which flashes straight to the root of things, a creative mind combined with astute judgment and practical organizing ability, a broad grasp of big issues, a long view, an unshakeable courage and enthusiasm, a dynamic energy that never seems to run down. All these, with broad culture and personal charm, make her a woman who easily ranks with the really outstanding reformers and educators of America.

In addition she has the love and devotion of an innumerable number of nurses whose lives she has influenced and glorified by helping them to see how potent a factor for human betterment the highest type of nursing service truly is. She it is who has held many of them to irksome and difficult tasks long after their own desire for release was most compelling—yet not quite as compelling as the urge of her example and advice.

It is given to only a few to know what a Mecca her office in Teachers College is to the principals of schools of nursing, who invariably turn to her in times of stress and who carry away with them something of her spirit to serve as a guiding star in trying hours.

Yale University can have little conception of how it has endeared itself to an enormous army of women workers who glory in the discernment it has shown.—CAROLYN E. GRAY, R.N.

An Announcement

The Modern Hospital Publishing Co., Inc., announces a competition for plans of a

Small Community Hospital

in order to stimulate a greater interest in the construction of economically arranged and architecturally artistic hospitals, and in order to provide boards of trustees of small institutions with a group of suggestive plans that will make for more efficient care and treatment of the sick.

$1,000 in Prizes

will be given to architects through the competition, the general program of which will be announced at the twenty-fourth annual conference of the American Hospital Association to be held at Atlantic City, September 25-28. Three cash prizes of $500, $300 and $200 will be awarded, and two honorable mentions made.

HOSPITAL ACCOUNTING*

IN A discussion of accounting in hospitals, one must first of all definitely set up the principles of accounting. Accounting methods were devised primarily to furnish a permanent record of the income and expenditures of activities. It is only in late years that we have seen the development of the broader use of accounting, i. e. the study of these records in order to determine the relative degree of efficiency of the activity under discussion. Therefore, any system of accounting that does not serve a dual purpose, first, that of a permanent record of professional, vital and financial performance, and second, that of a vehicle for studying these performances in an analytical way, has definitely failed in its function.

This article in no sense of the word will attempt to discuss other than a vital and financial accounting of an institution.

It must first of all be accepted that with the exception of small hospitals no performance can be analyzed without a very definite segregation, first, of income and expense and a differentiation of what income and expense is, as between corporation income and expense, and operating income and expense; and, second, the very definite segregation of various characters of income, both corporation and operating, and of expense both corporation and operating. It is further believed that the principle of departmental control of budget also must be very definitely accepted, to the end that the department head's performance shall be based on a large measure on the status of his or her departmental expenditure at the ends of given periods.

Equipment and Personnel

The accounting department of a hospital must be considered as a primary activity of the institution and personnelled accordingly. This committee would not presume to suggest the number of individuals who should be employed in taking care of the accounts of any institution, but it does suggest that the capabilities of such individuals be considered very definitely before making appointments, and that the appointments be made with the primary thought of the ability of the individual to furnish the administrative officer such tables of statistics as will permit of a study of his performance and such statements of the status of accounts at current periods as will permit the administrator to know at all times just what he is doing. It must be borne in mind that figures of this type which are not available immediately lose their value in increasing proportion to the length of time they are lacking. Therefore, the practice of some hospitals of waiting for the certified accountant at three, six and twelve months periods to furnish them with a statement of their financial performance sets up a handicap to administrative officers that is unfair. The accounting personnel of the institution should be competent to furnish figures to the administrative office immediately following the end of each month.

The type of record that is made in a hospital is not so important, except in that unless records are uniform, it does not furnish comparisons with other institutions of the same class. It was in an attempt to establish a uniformity of practice that the Committee on Forms and Records spent so much time in submitting a complete accounting practice for an institution. Better judgment should dictate that these records be uniform, that they be kept on standard sized paper capable of being filed in standard sized equipment. Further than this, it is of course a problem of the individual hospital.

Corporation Accounts

Many reasons exist for a complete separation of corporation and operating accounts. The growing general practice of recognizing pay, part-pay and free patient days as a sound principle, and the consequent necessity for knowing what the cost per patient per day is requires the establishment of a definite basis for this computation. One of the constants is the total cost of operation. It is unfair to include in operating expenses certain corporation expenses that vary in different hospital corporations. It is desirable therefore, in the opinion of the committee, to give herein the elements of corporation accounts in order that they may be a basis for the establishment of a uniform practice throughout the country.

The permanent assets of a corporation should be:

1. Land
2. Buildings
3. Equipment
4. Endowment and trust funds
5. Building funds
6. Investments.

There should also be an item of appreciation and depreciation, if in the judgment of the administrative board this should be considered in the corporation balance sheet. Any new additions to land, building or equipment should of course be written into this corporation account, but these items should in no sense of the word be affected by obsolescence or replacement of buildings or equipment. These expenses should be written into operation.

Corporation income should include the income from endowment and trust funds, rents and interest from investments and miscellaneous items.

Certain incomes of permanent investments are properly creditable to operating income and there is provided in operating income accounts provision for the care of this item. It is believed, however, that the corporation should set up its procedures to take care of such an item in corporation income transferring by book entry these incomes to the operating ledger.

Corporation Expenses.—Under this heading should be included salaries of officers and personnel, supplies incident to purely corporation activities, legal expenses, interest on loans, mortgages, etc., campaign expenses for raising funds and miscellaneous items.

The listings above are the minimum permanent requirements, as the committee sees it, of the corporation accounts. They of course may be amplified in keeping with the demands of the individual hospital.

Operating Accounts

Income Accounts.—In operating accounts the necessity for the segregation of items for purposes of study is much greater than in the corporation accounts, and therefore the committee feels that it should lay particular stress upon the two schemes submitted in its report. These income accounts should include every income from hospital function and may be divided with equal efficiency in either of the two ways submitted dependent entirely upon the principle of operation established by the hospital.

*This article, prepared by A. C. Bachmeyer, M.D., F. E. Chapman, and John Bresnahan, M.D., is the second of a series of four interpreting the report of the committee on hospital forms and records which was made at the twenty-third annual meeting of the American Hospital Association in September, 1921.

Attention is called very definitely to the comments under corporation accounts, having reference to endowment earnings.

Expense Accounts.—The departmentalization of operating expenses, it is believed, is a fundamental of proper hospital accounting and just as basic in arriving at the cost of the procedure as is the departmentalization of the expenses of operating various departments of an industry. If one attempts to combine the activities of the dietary, the nursing and the mechanical departments, their performance cannot be studied with the degree of efficiency that is possible if a definite chart of accounts by departments is set up and the cost of all commodities charged to the proper department. Specific reference is made to the practice in a large number of hospitals of carrying an item of "payroll" on their books in which account all salaries and wages of the hospital are charged. This does not permit proper control of funds.

Attention is called to the detailed report of the committee that has attempted to go into this question at length.

Patients' Accounts.—Another phase of hospital operation and probably the most active phase is the proper recording of individual patients' accounts. Such records divide themselves into two classes: vital and financial. The vital record is discussed in detail in the first paper of this series. The financial record, in the opinion of the committee, should be as simple as is consistent with good business practice, the permanent record carrying only such information as is pertinent to the financial problem of the patient. The only requisite in this case is that the record be in such shape as to permit the maintenance of a definite control account. There is no reason why a hospital cannot balance its accounts every night just as do banks. Such a procedure does not require any greater expenditure of time or energy than the present rather lackadaisical methods existent in most of our hospitals.

Records and Analysis

It is believed that an expression of the purpose of the accounting department of a hospital cannot be more clearly set forth than it has been done in the introduction of Subdivision I of the report of the Committee on Hospital Forms and Records, and for purpose of easy reference this paragraph is quoted herewith:

> "Any recording system, whether it concerns professional, financial or administrative activity, is not productive nor does it approach its potentiality for good unless it furnishes a basis for the analysis of results. It is our belief that too much stress cannot be placed upon the necessity of having a routine mechanism for this purpose. Unless by arrangement an analysis of hospital records is made routinely, the tendency to neglect this very important phase of administrative duty under pressure of other work, is very great.
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> "It is, however, recognized that no committee is capable of setting up a uniform system for producing such an analysis, suitable to all types of institutions. There are certain basic principles applicable to any institution, and it is these principles with which the committee is concerned."

Certain comment on the committee's work charges that it sets up a degree of red tape out of all proportion to the good to be derived. Your committee submits the counterstatement that the reason our hospitals today are being criticized for lax methods of administration is that there has not been recognition of methods for intensive study of procedures, and that the set-up of the committee will not be productive of red tape but will only introduce machinery absolutely necessary for the efficient operation of so complex a procedure. There must be set up a mechanism to furnish daily and monthly financial, vital and professional records of the performance of the institution, if the administrative officer is to be cognizant of the activity he is serving. These figures will serve their maximum value if they are put in comparative form daily, in order that the administrative officer may have a picture of the continuous performance of his institution. They will be still more valuable if they are made uniform for hospitals all over the country so that executives may have the benefit of the performance of other hospitals as a basis for judging their own. These figures, unless they are uniform, are of no value. Your committee feels that a comparison of the per capita cost of hospitals in the country today is of no value by reason of the fact that there is no uniformity in the computation of this cost. For ease of reference there is inserted herein again a formula of computing ward census or total days' hospital treatment given, submitted on page 15 and 16 of the report of the committee. Using this figure as one of the two constants, the other being the total cost of operation for a given period, the per capita cost of any institution's performance is easily arrived at.

The determination of a proper per capita cost is based upon accurate ward census reports. The daily census should show the following formula:

1.	Patients remaining in hospital midnight	(Aug. 10)—	200
2.	Patients admitted to hospital	(Aug. 11)—	22
3.	Births	(Aug. 11)—	3
			225
4.	Patients discharged	(Aug. 11)—	10
5.	Deaths	(Aug. 11)—	2
6.	Patients remaining midnight	(Aug. 11)—	213

The last item also represents the "days' hospital treatment given."

It frequently happens that patients are admitted and discharged on the same date. This formula does not credit a "day's treatment" for such cases, and they should therefore be added to the last total in determining the total "day's treatment" rendered on any given day.

This formula records the day of admission as a day of treatment. It does not record the day of discharge as a day of treatment. The method illustrated, however, is the logical method to use. Including both day of admission and day of discharge produces a false and exaggerated figure.

Actual calculation has proved that the law of average applies in the formula cited to produce accurate statistics.

To obtain the total number of treatment days for any given period, the accepted formula is as follows: to the sum of the midnight census for a given period add the number of patients who were admitted and discharged on the same date during that period. This formula should be used in computing average per patient per diet cost. It has no bearing on charges made to the patient.

PURCHASE AND ISSUANCE OF SUPPLIES*

The committee wishes to reiterate the point made in its original report as to the importance of a strong mechanism in that department of the institution's activity which has to do with the purchase and issuance of supplies. There is no desire to set up an elaborate system of red tape, but rather to err on the side of simplicity. It must be recognized that purchasing of commodities is a science in itself, and that a hospital will do well to pay more attention not only to the purchase but to the issuance of its supplies. The plea is herein offered for more careful planning of purchases.

Avoid indiscriminate ordering. Anticipate wants. Make purchases dependent upon the quality of the merchandise. Watch the trend of the market. Purchase in quantities dependent upon that trend. Take advantage of seasonal

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buying wherever possible. Draw up for yourself specifications of what is desired, just as carefully as it is possible. Make them explicit and then see to it that the goods come up to the specifications set forth. Make your purchases on a basis of competitive bids. Originate a purchase record system to the end that your purchasing agent will know what the prices and terms of the commodity purchases are, and when you have consummated the detail of the purchase, put it down in writing and make that written order in detail to include terms, specifications, reference and price.

After having established an efficient purchasing system, a hospital has taken a long step in the right direction, but not the most important step by far. Many times as much money can be saved in efficient issuance as can be saved in efficient purchase. First of all a definite principle must be accepted, and that is that the consumer of the commodity should never control the storage of the supply of that commodity. This principle should be extended to include the further regulation that the purchaser in very large measure should have nothing to do with the storage of the commodity. It must not be understood that we are going on a basis that our personnel is dishonest, but to err is human, and it is incumbent upon hospitals to set up as many safeguards as possible around so important a part of the operating cost as is the purchase and issuance of supplies.

The next step is the establishment of a receipt form in duplicate, the original to go to the accounting department and the duplicate to remain in the storeroom for a record. Reference is made to the form under B-1-C in the report of the committee.

A permanent record, not only of the commodities received but of the points to which these commodities are disbursed is important and enables the administrative group to know the amount of a given commodity in storage at given time. To this end, it is necessary to develop a perpetual inventory. Reference is herein made to form B-1-F of the committee's report. It is suggested further that the inventory and the financial classification of the hospital be identical to the end that inventory adjustments may be made at given periods.

Efficient issuance in an institution is easy of accomplishment if the degree of energy and intelligence is applied to the problem that its volume indicates. The line of least resistance prompts all of us to use that of which we have most. Therefore, if we are to have economical consumption of our supplies, it is highly desirable that we do not have an oversupply at any one time on any unit. It is much better to issue supplies frequently in small quantities than to issue large quantities at indefinite periods, and it is recommended by the committee that all hospitals establish specified requisition days once a week for every activity other than the dietary, and once a day for the dietary. Requisitions, it is believed, should be in blank, and not on suggestive printed forms as are used in a great many of our institutions. Reference is made to form B-1-E in the report. These requisitions should be definitely approved by the administrative officer or some one present directed to render this administrative function. Indiscriminate approval of these requisitions should not be countenanced. The further principle of redeeming consumable and usable supplies wherever possible by return of the broken article for redemption should be established. The psychology of such a procedure is absolutely sound and productive of results.

BUFFALO PLAN OF HEALTH SERVICE UPHELD

SWEEPING charges of extravagance, mismanagement and inefficiency brought last January by the mayor and members of the city council of Buffalo against the department of hospitals and dispensaries of that city have resulted in the substantial vindication of the department by the practical withdrawal of the mayor's attack and by a report just published under the auspices of a committee of 132 prominent citizens of Buffalo.

The attack upon the department resulted in the organization of this committee which demanded that a study be made of the entire situation by an impartial outsider. The committee called in Dr. Haven Emerson of New York, who was formerly commissioner of health of New York City, and has a record of distinguished war service abroad. Dr. Emerson was also director of the Cleveland hospital and health survey and has just been appointed professor of public health administration in the College of Physicians and Surgeons, Columbia University. In Dr. Emerson's report, just published, the department of hospitals and dispensaries of Buffalo has not only emerged unscathed, but with flying colors.

Hospitals Department is Vindicated

As a result of first hand observation by Dr. Emerson and his associates, a full report has been presented which not only endorses the work of the department of hospitals and dispensaries but is of great general interest. It states and defines standards of hospital service for a community, describes the essential elements of efficient management, as illustrated in Buffalo; the correlation of public and private agencies; and the services rendered to private physicians through furnishing diagnostic facilities.

In 1910 a general survey was made of the hospital situation of Buffalo by the standing committee on hospitals of the New York State Charities Aid Association resulting in a recommendation that a new general municipal hospital entirely separated from the poor department and almshouse, centrally located, having a minimum of 720 beds, (200 for tuberculosis, 200 for chronic cases, 100 for acute cases, 200 for contagious diseases and 20 for detention cases) should be built by the city, and that this hospital should be constructed in accordance with a comprehensive plan adequate for the rapidly increasing needs of the growing city. It was provided that construction and management should be intrusted to a board of managers.

Acting on this recommendation the city council at once advised the building of a general hospital with 500 beds for medical and surgical cases and 200 for contagious diseases.

In 1917 the department of hospitals and dispensaries was reorganized. This department was an outgrowth of the bureau of hospitals of the department of health which was at that time operating the Ernest Wende Hospital and the five dispensaries. The board of managers consists of five men, appointed by the mayor for terms of five years each, one to be appointed and one retiring each year, and all serving without pay. This plan has proved effective in giving stability and continuity of policy.

The department of hospitals and dispensaries embraces (1) the Buffalo City Hospital, offering general medical service except the care of communicable diseases and hav-

ing 415 beds; (2) the Municipal Hospital with 175 beds caring for tuberculosis and venereal disease; (3) the Ernest Wende Hospital, 140 beds, providing for other communicable diseases; and (4) seven "health center dispensaries." The last provide clinics for medical and surgical diagnosis and treatment, general diagnostic clinics for children and adults. Drug addict clinics, prenatal care of expectant mothers, prophylactic and corrective dental care, well baby clinics, tuberculosis and venereal disease clinics are maintained in these dispensaries by the department of health. A mental disease clinic for adults and children is served by physicians from the Buffalo State Hospital of the state hospital commission.

In addition to the health facilities offered by the department of hospitals and dispensaries, public facilities include the J. N. Adam Memorial Hospital for tuberculosis with 350 beds under the auspices of the health department and the Erie County Hospital with 300 beds. Privately controlled institutions have an aggregate of 1788 beds, making a total of 3,168 available for the city of Buffalo with a population of 506,775 or for Erie County with 650,000.

Erie County Standards of Service

Standards of hospital service to the community as represented by the number of hospital beds in relation to the population have been worked out by Dr. Emerson and others in Cleveland and elsewhere. The following table shows these standards and their application to Erie County:

Kinds of service	No. of beds usually needed for 100,000 people	Needed in Erie County (Population 650,000)	Beds provided in Erie County per 100,000	Provided in Erie County (Population 650,000)
General medical and surgical care	500	3,250	334	2,169
Children	50	325	49	319
Maternity cases	15	98	37	241
Acute communicable	50	325	21	135
Tuberculosis	92	600	132	862
Convalescent care	*7	*7	.....	.....
Total	707	4,598	573	3,726

*Per 1,000 hospital cases.

When the buildings now under construction are completed and the number of beds indicated in the last column of this table are in operation, it will be seen that there will be in Buffalo adequate provision for children and for obstetrical cases, an overabundant provision for tuberculosis and only slightly deficient provision for general medical and surgical care. There will remain a deficiency in the number of beds for contagious diseases and above all a serious lack of any provision for convalescent care. Dr. Emerson recommends various adjustments of hospital provisions which will tend to improve the situation.

The use which has been made of the health facilities of Buffalo is perhaps the best indication of their need. In the three hospitals under the department of hospitals and dispensaries, 88 per cent of the bed capacity was in use throughout 1921, a percentage which is only equalled by the two larger New York hospitals and which is 22 per cent higher than in the twenty-one hospitals studied in the Cleveland survey. In the United States government hospitals the percentage of occupancy has been less than 80 per cent during the last three years. It is usually possible to take care of all men applying for care in these three hospitals but the women's department is as a rule overcrowded, and women patients must be frequently sent to other hospitals The branch dispensaries show an attendance of 192,213 visits made by patients during the year, representing 31,345 individuals.

The chief needs in the Buffalo health program are provision for convalescent care, prophylactic dental care in every branch dispensary for school children, occupational therapy in the hospitals, and the employment of nurses in the District Nursing Association to attend confinement cases under the direction of physicians. Baby welfare work is not as completely developed as some of the other phases of the work.

Hospitals Are Efficiently Managed

Efficient management is shown throughout the department of hospitals and dispensaries. All the activities are combined under one superintendent who is appointed by and responsible to the board of managers, which is kept away from political influence by its method of appointment and term of service.

The medical staff, representing as it does the teachers of the medical school of the University of Buffalo and such others as associates and assistants as are acceptable to the college and the department, is organized according to the best hospital practice. Staff meetings are held regularly, careful records are kept, and the executive committee is composed of the chiefs of the sixteen professional sections. Continuity of service for the section chiefs, responsibility for appointment, and supervision of the professional care of patients in the sections are effectively provided for. The outpatient services are an integral part of the work and responsibilities of the section chiefs. The coming and going of the attending staff are registered and the time they spent in the wards compares favorably with the practice in the best hospitals of the country.

Cooperation is provided with private practitioners of medicine not on the visiting staff, by permitting them to follow up and observe patients referred by them and treated at public expense. When pay patients are admitted, they may be attended by the referring physician in conformity with the standards of professional and administrative practice of the department. The record system of the hospitals conforms with the standards laid down by the American College of Surgeons. The duties and relations of all employes to each other and to the patients have been worked out so as to insure the best possible coordination of the entire hospitals and dispensary organization.

Efficiency of administration is demonstrated also in the financial management. The costs of hospital and dispensary services, best expressed in terms of cost per patient day and per dispensary visit, are $3.79 for the former and $.70 for the latter. These figures compare favorably with the cost of services of similar quality in New York and Boston.

Since the admission of patients for free medical or surgical care requires that they be unable to pay for the services of private physicians, it was necessary to find adequate measures for determining the economic status of all applicants for free care. An arrangement was therefore made with the city bureau of public welfare, whereby the bureau acts as a social service department, passing upon all applications for treatment made to hospitals or dispensaries, excepting those coming from certain recognized agencies, such as the Charity Organization Society,

the Jewish Federation of Charities, District Nursing Association, Bureau of Child Welfare of the Department of Health and the Erie County Superintendent of Poor. Cases referred by private physicians for care in the dispensary diagnostic clinic are admitted without further investigation. As a means of determining a patient's inability to pay, a statement of the cost of living, based on a minimum standard of decency, is issued at intervals by the Charity Organization Society. This standard is used by the bureau of public welfare, the department of health and the district nursing association. Requests for hospital care are handled by a separate division of the bureau of public welfare, having three visitors and a director. While this staff is limited, full use is made of the social service exchange and records of other organizations, saving much time and money. The patient or a responsible member of his family also signs a sworn statement of inability to pay. Out of a total of 6,361 applicants, 607 were refused assistance because they were considered to be able to pay. For those unable to pay at the time of treatment, a system of deferred payments is arranged and through this means $15,124.45 was returned last year.

That abuse of the privilege of free treatment may occasionally exist to the loss of the taxpayer, in spite of the carefully developed and effective plan of investigation as outlined above, is obvious. An investigation of the situation, however, did not reveal that this existed even to the extent of five per cent of the general run of patients treated in the year by the department of hospitals and dispensaries. A questionnaire sent out by the Erie County Medical Society to 668 physicians resulted in the reporting of only seven instances of fraudulent applicants treated by the department of hospitals and dispensaries and one by the department of health.

Cooperation Between Agencies

One of the distinctive features of the Buffalo plan is the cooperation among the city departments dealing with health and welfare, and also with the municipal and private agencies. The relations between the department of hospitals and dispensaries and the bureau of public welfare provide a proper sharing of responsibility without duplication of effort in relation to the financial aspect of the patient. The department of health also has intimate participation. This department provides, in addition to the usual preventive and sanitary measures, the J. N. Adam Memorial Hospital for Tuberculosis, well baby clinics, prenatal and pre-school care, inspection of school children, examination of subnormal children, supervision of midwives, and examination of children for working certificates. The utilization of the buildings of the "health center dispensaries" for many of the clinical activities of the department of health is a measure of economy and efficiency.

The District Nursing Association of Buffalo illustrates, as the Charity Organization Society, the close cooperation of private with municipal agencies. The staff of the nursing association makes an average of over 12,000 visits per month. In cooperation with the city, the nurses provide not only the general bedside care in the home of all cases including communicable disease and tuberculosis, but also attendance by the nurses at the baby clinics, at the central clinic, and social service work in connection with the diagnostic clinic.

Finally, association with medical education is not lacking. The department of hospitals and dispensaries is affiliated with the medical school of the University of Buffalo, the staff of the hospital being under the control of the university. Doctor Emerson remarks that the completeness of the medical service offered by the hospitals and dispensaries and the control of the professional positions for teaching purposes are unusual and redounds to the credit of both institutions. It is suggested that a nursing school as well as a medical school might well be placed under the control of the university.

Diagnostic services for private physicians is one of the distinctive and far-reaching advantages of the Buffalo plan. During a period of two years 272 physicians sent 772 patients to the free diagnostic clinic. The city physicians in the employ of the department sent during the same period 2,577 patients for various diagnostic service. Every case sent by a physician to the diagnostic clinic receives careful study and the physician receives a full written report of findings and recommendations. The City Hospital has likewise received a large number of patients from physicians. In 1921 out of 800 physicians in Erie County, 305 sent a total of 752 patients to the hospital. It is interesting to observe, says Doctor Emerson, that of these eight hundred physicians, about two hundred are engaged in some kind of work for the federal, state or municipal governments for pay.

Recommends Extension of Buffalo Plan

The concluding sections of the report make recommendations for consolidating and extending the benefits of the existing Buffalo Plan. The report says:

"It would appear in Buffalo that there is lacking that spirit of professional fellowship and mutual confidence and respect which must be created and cultivated if the five medico-social professions, medicine, nursing, pharmacy, dentistry, and social service, are to achieve the results the community has a right to expect, and each develop within its own special field to its full possibilities without sacrifice of the independence or adequate financial emoluments of any one of these necessarily allied professions.

"It is believed that once the public recognizes the need for adequate social service and the physicians accept this new group of associates as trusted allies, the present roughness and mistakes due to misunderstanding and insufficient support will largely disappear.

"It must be a matter of common knowledge among physicians of Buffalo as it is elsewhere that the great reduction in the incidence and deaths from preventable diseases during the past twenty years has been the main factor in altering the character of medical practice and changing the courses of income."

To meet this situation, Doctor Emerson makes a number of recommendations, such as a further careful study of all public and private health activities, with special reference to tuberculosis; a central association of all the hospitals for the discussion and establishment of common hospital policies, and also to provide for economy through central purchasing; and finally, to meet the main need, there is recommended a permanent public health committee. On this should be represented the medical profession, also public and private groups interested in health problems; labor, business men, and other citizens. The temporary citizens' committee under whose auspices the investigation was conducted furnishes a nucleus for such an organization. A standing committee of this kind would, it is believed, bring together the points of view of groups that now fail of mutual understanding and tend towards the permanent advancement of medical work and of the larger interests of the community in health and general welfare.

"The student nurse is a financial asset to the hospital which graduates her. Therefore she should be entitled to at least as great consideration on the part of the public as are students who remain permanently in debt to the institution which graduates them. But as a matter of fact this is not the case, because the public seems to be largely unaware of the fact that schools for nursing are still, in the majority of instances, sacrificed to the practical exigencies of the hospitals which maintain them, and too often the nurse gives three years of service in return for little more than an apprenticeship."—*Selected.*

OCCUPATION FOR CHILDREN IN HOSPITAL WARDS

By ISABELLE L. WHITTIER, Massachusetts General Hospital, Boston, Mass.

FOR over a year now I have worked in the childrens' ward of the Massachusetts General Hospital, trying to find what two hours daily of organized play will do for sick children. My aim in this work is to make the wards more a place of joy and less of suffering and to make children more easy for the doctors and nurses to manage. I have even hoped that recoveries of children, whose minds were diverted from their suffering, would be more rapid. During my hours in the wards I have never urged a child to do what he did not wish to or insisted that work begun should be finished if the child seemed tired. I have tried to make the wards a quieter rather than a more noisy or confused place.

Baby likes a red ball.

In order to divert children of all ages—from those of a few months old up to those of thirteen years—I have been obliged to use all I have had in experience and training. My training has consisted of a course in kindergarten and some years of teaching, a course in Montessori method and some months observance of them in the schools of Rome, Italy; three years' experience in story-telling in libraries; and—most valuable of all—I have had, for twenty years, all the children for their first year in one of the Boston settlement houses.

Miss Two-Year-Old favors these Montessori cylindrical wooden insets.

We have in our wards thirty beds for medical and surgical cases, The beds are occupied by children of all ages, and they stay different lengths of time from a few days up to three months. About half of them are foreign born and some understand very little English when they come to us.

For the babies I use the kindergarten balls, soft worsted balls, with strings of the six primary colors. First I use only the red ball moving it as I say, "Up, up, up"—"Down, down, down,"—"Swing, swing, swing." I often hear the babies repeating the words over and over, after I leave them with the ball tied on the sides of their cribs. When I want to stimulate a slowly convalescing baby I tie all six balls on the side of the crib and set them swinging. I believe that watching a swinging red ball is the earliest lesson in concentration. Besides the ball experiences, which I consider the babies' work, we play. I do the "Creep mouse, creep mouse" and the "Peek-a-boo," letting the baby pull the handkerchief from his eyes. I depend on these plays to make the babies laugh aloud at least three or four times each day. I give the ten red cubes of graduated size (Montessori) after the worsted balls. These blocks, being without the usual distraction of letters or pictures, give a quick understanding of the terms "big" and "little," and a possible realization of form and size gradation.

At two years of age, children like to play with the cylindrical wooden insets (Montessori). There are three sets of these cylinders to be fitted into holes in wooden bars. They differ in height, in diameter, in both. I have seen children put them in and take them out forty-three times at one sitting. I teach these children colors with the kindergarten balls and their letters with blocks. With the frames of wooden beads I begin counting. The older ones string wooden beads, alternating colors. When these children are well enough I carry them pig-back about the ward, touching and naming objects and talking with the other children in bed. We toss bean bags to give them a better appetite for dinner the latter part of the morning.

For children four, five and six years old, I use sense and memory games. I have a tiny chest of drawers which is very popular. I blindfold the children, they open a drawer take out a piece of linen, cotton, silk or velvet, I let them feel it carefully and tell me the name of the material.

The six Montessori dressing frames are useful to me. With them I teach buttoning, hooking, ball and socketing, lacing and the tying of bows. I always follow this occupation by practical work with blanket wrappers and boots. A child sometimes learns to dress himself for the first time while he is with us. With my six wooden boxes (Montessori) containing flaxseed, sand, corn, gravel, pebbles of stones, the children learn to distinguish gradations of sound. They shake them one at a time, and tell me which is loudest, which next, etc. I have even given doctors a superficial verdict of hearing by request. The child is so eager that he is not self-conscious or doubtful and results are pretty accurate. To

"What time is it?" (If the little patient can answer that question from the clock in the picture, she is a wonder).

promote quickness of vision and memory for six year olds, I display a number of objects for about thirty seconds on a tray, cover them with a cloth, and ask the

Almost to the Mason-Dixon line.

children to tell me what they have seen. After taxing sense exactness we blow bubbles or I show them my handkerchief tricks—the little boy that dances when you count three, the rabbit that hops and the graceful court lady that courtesies.

After six years of age, I find I have to differentiate my occupations for boys and girls. They both like paper-cutting of snowflake patterns and the folding of paper into more or less elaborate forms. And they like the clay from which we mould apple, pears, and snowmen, sometimes using it to illustrate the story which I tell. Little girls like to play dolls with a collection of dolls' housekeeping articles which I have picked up. Boys like to use the (Montessori) flat geometrical insets. They like to lift the squares, circles, triangles, etc., into their right places blindfolded. I tell them of diameters, diagonals, circumferences, etc., as I present each new figure. Then they draw the figures, fill them in with colored crayons and print the names underneath. These children play ring-toss and throwing of the bean bags with clapping of hands, before catching.

Nature Interests Older Children

I get ideas for occupation of children from eight to fourteen years of age from varied sources. In the spring, I hang up one of the Audubon bird charts and ask a child to pick out a bird that he likes. We find the bird's name from the glossary at the foot of the chart and I read the account of that bird from the Burgess bird book, in which Peter Rabbit and Jennie Wren converse about their bird neighbors. In the summer, I get colored plates from the American forestry department, showing the gypsy and brown tail moths and their antidote, the Calsoma beetle. We talk about these tree pests and the beetle that was brought across the ocean to destroy them and they promise to cherish the "good ones" and destroy the "bad ones."

The Geographical Magazine of a few years ago contained some delightful pictures of our American wild flowers. I gave these pictures to a boy with heart dis-

Silk or velvet—which?

ease in the early summer and brought him a fresh flower each day. He looked over the pile of pictures and told me the flower's name before the end of the morning. Beside the Wild Flower number, another Geographical Magazine had pictures of flags of the different countries. The boys have looked at this copy until it is in shreds. They pick out a flag, draw and color it with crayons or water colors. I give the older boys hinged cigar boxes, from which they sandpaper all printing and paper labels. Then we paint them black on the outside and red inside and paste a picture on the cover. When they are varnished they make pretty workboxes for presents. While the older boys are working on flags and cigar boxes I am teaching the older girls to knit, crochet, make worsted flowers and, with the help of the Mary

"I'm forever blowing bubbles."

Bean bag brings bright eyes and broad smiles.

Francis book on sewing, to make dolls' clothes, if they wish. Both boys and girls like the big map of Fairyland which I use as a stimulus for story telling. Other suggestions for stories come from the rolls of crepe paper that I get at Dennison's. They contain appropriate pictures for the holiday stories, Browning's Pied Piper, etc.

I use a great many picture puzzles for children of all ages. I cut pictures from newspapers, magazine covers and advertisements. I stick them on pasteboard and cut them into shapes differing in number and difficulty. Even the young children can put together simple pictures which I try to make so bright and funny that they laugh when they see them completed. I follow the more difficult pictures with map puzzles of North America and the United States. Children from nine to thirteen years of age like to play dominoes and checkers.

We have so many foreign children that I try to do a bit of Americanization work sometimes. For several days before the fourth of July last summer, we were talking about the American flag and making it. Then I taught them all how to salute. On July 4, I borrowed the big and very beautiful silk flag from the hospital library and marched around the wards with it, pausing at each bedside for their salute.

Besides bubbles, balloons and bean bags, there is something else all children like. Parties! We have one, at least, every month. At all parties my fairy chair appears. It is a small gilded chair gayly upholstered with flowered brocade, with a music box inside the seat. I say: When a good child sits in my fairy chair it plays a tune. One by one, I wrap each child, that may be moved, in a blanket and place him in the chair. My chair does not play directly a child sits in it. There is a slight pause, during which I watch the moment of suspense on the child's face when he evidently remembers, with consternation all the naughty things he has ever done and wonders if the chair knows. * * * The tune begins. A gasp of ecstatic joy is the result. They usually end by asking me to sit down in it. I refuse, principally, I acknowledge, to hear their assurance, "Oh Miss Isabelle, we know it will play if you sit in it." Another thing that makes a party is a lovely pink crepe paper flower-petaled Jack Horner pie. I fasten small toys to the end of pink ribbons, conceal them among the petals and each child pulls one out. I also use fancy bonbons which snap and have presents and paper caps inside for special occasions like birthdays.

This gives a general idea of my methods.

Splendid work is being done for children in the Boston City Hospital. The work is done by a public school teacher employed by the city. She finds from a child's teacher exactly what work they are doing in his class and gives the child in the hospital (generally an orthopedic case) exactly the same lessons. In many cases, when he returns to school, he has not dropped behind his school mates. This plan is only adopted, however, for those children who are to be in the hospital about three months. As the work is under the supervision of the Boston school board teachers are obliged to cooperate and the same textbooks are used in all Boston schools. In the Massachusetts General Hospital this scheme would be impossible because children come from all over the state, different kinds of textbooks are used and public school teachers would not be obliged to arrange the work. Also, I like better the work with any and all children that need attention. Often children that are with us for a few days only would spend most of their time crying from homesickness if left to themselves. So I do little school work unless there is a special reason for it. There sometimes is. For example, we had one diabetic girl who was with us a long time. Each day, as the ample dinner of chicken, potato, spinach and ice cream came in for the other children, she would go away by herself and cry over her scarcity and lack of appetizing food. Each day, after finding out that she liked arithmetic, I gave her a lesson in arithmetic. Partly because I praised her and partly because she could show off a little before the happily eating children, she no longer dreaded the mid-day meal. Another case was a little boy, who was always writing letters and asking us how to spell simple words. I suggested to him that he find a list of ten words in books or magazines and surprise me each morning by spelling them for me. Before he went home he said to me "Why, Play Lady, when I was in school I didn't know I liked spelling, but I guess I do."

The hospital care of children, especially in a large general hospital, is quite different from the care in the private home. Because of the routine it is impossible to give the children sufficient amusement to keep them happy. Homesickness and unhappiness retard the recovery in some cases, and it is likewise true that when a child's mind is happy recovery is more rapid, treatment more satisfactory and the results better.

Miss Whittier has filled the lacking gap in our ward and the results have been beyond my expectations. Instead of being an independent unit complicating with medical treatment, she has so blended herself with the ideals of the medical and nursing staff, that I often do not know that she is present but only realize it when I see children gathered round her and laughing. There is rarely an unhappy or discontented face, and the ward instead of being noisier is quieter. Under certain circumstances Miss Whittier's cooperation in amusing and educating the children has been of more than academic and humanitarian interest because it has been of real therapeutic value and has hastened the cure of the child.

I feel that there is a place for such work as Miss Whittier carries out in all hospital wards for children.

FRITZ B. TALBOT,
Chief of Children's Medical Service,
Massachusetts General Hospital, Boston.

Many Makeshifts Are Necessary

My field of occupational work and play for sick children is new and I have not always been successful in my attempts. I have not yet found enough satisfactory occupations for the oldest boys. I am considering basketry work. I have had to discard some of the plays I should like to use, as being too noisy. I have not been able to use as much as I wish my favorite resort of story-telling because of necessary interruptions. Reading is better, because one can pick it up instantly. I have failed in finding any substitute for the "unsanitary" live pet, cat or dog, that I think is much needed in the wards. I have not yet procured the sand-box that I wanted for

our out-door porch last summer. I have failed to adapt for hospital use much of the kindergarten material. Its use requires too much supervision, but I have used kindergarten methods in making programs according to seasons and holidays. The Montessori materials are better for hospital. If rightly presented, children teach themselves by using them.

Length of stay in the hospital determines, to an extent, the importance of the results of my work. When a severe case of pneumonia comes to us, the crisis soon follows; if the recovery is rapid I do not get much chance to do anything for the child, but often recoveries are slow and I can give the necessary stimulus.

When children stay with us several months, as a number of diabetic, cardiac and malnutrition patients have, I find I can influence manners and habits and even dispositions somewhat. I am daily proving to my own satisfaction that there are no naughty children that are properly employed. I often write letters for the children to their parents, asking for the materials that I use in the hospital; a paint-box and brushes so that he can make flags when he gets home was the request of an Italian boy. Painting, with this child, was like an obsession, so that I wondered if we might be starting a young artist in his career. Another boy was so much cleverer than I with his clay that we may have an M. G. H. sculptor some day.

Work with children in a big hospital keeps one on the alert because of its variety and necessary makeshifts. Difference in the ages of children and their degree of strength make changing and adapting as important as the original knowledge of appropriate employment.

HOSPITALS IN MANCHURIA

Hospitals of Southern Manchuria are treated in an article in a recent issue of *The Hospital Gazette*, a London publication. The three types of hospitals in operation in Manchuria are those maintained by the local government, the South Manchuria Railway Company and the Red Cross Society of Japan.

The principal hospital which serves the district near the seacoast of the Pe-chi-li-strait is the Kwantung Government Hospital at Port Arthur. During the old Russion regime this hospital was under the administration of the Red Cross. It is well equipped with all the usual special departments.

There is also an isolation hospital at Port Arthur with 160 beds, and another at Dairen with 70 beds. Both at Dairen and Port Arthur also there are special hospitals for diseases of women. All of these hospitals are under the direct management of the Kwantung government.

The South Manchuria Railway Company maintains hospitals in Dairen, Mukden and fifteen other towns, of which the Dairen Hospital is the largest. The Mukden Hospital is attached to the South Manchuria Medical College and is equipped with up-to-date medical appliances. According to an investigation recently made, these hospitals can accommodate 1,962 in-patients; their medical staffs total 213; pharmaceutists and mechanical experts 104; and nurses and midwives 513.

In addition to the hospitals under the management of the South Manchuria Railway Company, there is within the walls of Mukden another hospital under the management of the Red Cross Society of Japan, which is a newly-constructed building on quite a large scale. This society also maintains a dozen medical stations in North and South Manchuria for affording temporary medical and surgical relief. Apart from the medical facilities enumerated, a large number of private hospitals and medical stations also exist at some of the important centers.

HOSPITAL COT IS GOOD CIRCUS SEAT

Hospital cots were reserved seats at "the greatest show on earth" recently when 900 patients at the Philadelphia

Photo by Underwood & Underwood.
Choice seats at this circus are hospital cots.

General Hospital recently witnessed a private circus performance.

The blood-sweating hippopotamus and man-eating tiger were not among those present, nor were pink lemonade and peanuts in the shell dispensed to those on light diet, but the clowns and acrobats of the Ringling Brothers and Barnum and Bailey circus performed for two hours to the intense delight of the bed-ridden spectators.

Maggie, the pig, extends greetings to the patients.

Not the least of the pleasure was the visit of Maggie to each cot that bordered the impromptu circus ring. Maggie, a trained pig, squealed to each patient the wish that he soon would become well.

The mind impervious to new ideas, the mind hermetically sealed, will find no advocate and needs no prosecuting attorneys; one may be no fresh-air enthusiast and yet value good ventilation. For a tubercular or atrophied mind one may well prescribe a regimen of open air; but the healthy mind needs its inclosing walls and its fireside, where it may be at home. It will slowly extend its walls, open new windows to the east, build itself new watch towers; it will from time to time issue forth on travels of high adventure, and bring back the wealth of Asia or sail to new Americas; but, weary of wandering through eternity, it will, unless it be a mere "hobo" of a mind, seek its fireside and its four walls. There it lives, there it builds itself walls of prejudice; the greater mind fashions them out of convictions. The truly open mind can have neither the one nor the other. Better walls of prejudice than an ineffectual homelessness.—Robert Kilburn Root.

SUPPLANTING THE MEDICINE MAN*

By ARTHUR E. MIDDLETON, Chief of Construction Section, Indian Bureau, Interior Department, Washington, D. C.

HOW the U. S. government in a few short years has broken down the powerful influence of the "Medicine Man" among the native inhabitants of this country and has erected for the Indian population a great series of modern hospitals has been told in a preceding article. Just what the government has done for the tuberculous Indian in the way of supplying institutional care for him was described at length. This article will confine itself to the general features of construction in the school and agency hospitals.

The Kiowa Agency Hospital

The hospital at the Kiowa Agency in Oklahoma was built in 1915 under contract at a cost of $38,000, is one of the largest of the Agency hospitals and is well arranged for the treatment of general cases for which it was designed.

The superstructure is of brick resting on concrete foundations; it has select brick facings and hollow brick backing, cement window and door sills; the cornice mouldings, gable copings and porch parapets are of galvanized iron and the roof covering is dark blue slate. The interior finish is of No. 1 pine; door and window trims are plain; the doors are single paneled and the walls and ceilings are plastered with two-coat hard plaster on metal lath, except in the bath, toilet, serving rooms and kitchen, which are provided with composition wainscoting and flooring. The operating room is wainscoted with white bright glazed tile and has a floor of white vitreous non-absorbent tile. The provision for securing admission of daylight to this room is worthy of special mention. A one-story bay projection, three feet deep, is placed at the outer end of the room and the wall space taken up almost entirely by steel casement windows, while a skylight glazed with rippled glass, extending across the entire bay, is inclined at an angle which throws the light well into the room.

Ventilation is secured by natural draft, through vent flues connected to roof ventilators by ducts in the attic. Concrete floors are provided throughout the entire basement and double flooring throughout the first and second stories. The exterior and interior wood work excepting that of the stairs is painted three coats of best white lead and oil, the stair finish being first quality transparent varnish. The heating arrangement has been designed with due regard to the various activities administered in the building, the wards and operating room being provided with both the direct and indirect systems while the direct system is provided elsewhere.

The plumbing equipment is thoroughly modern, being of the manufacture and type meeting the requirements of the U. S. government standard plumbing specifications.

The building is provided with an electric lighting system installed in accordance with standard practice and the fixtures are of the types best suited to the use of the various rooms; automatic electric bell annunciator systems are also provided.

The Rosebud Agency Hospital

The Rosebud Agency hospital, named the Ashurst in honor of Senator Ashurst of Arizona, is presented as an example of the type designed for the treatment of both general and tuberculous cases. It was built in 1915 under contract and cost, exclusive of administrative and operative equipment, $33,000. It has a capacity of thirty beds. The interior and exterior walls of the superstructure are of brick, the exterior walls being backed with hollow building tile faced with selected red brick laid in common bond with struck joints, and the foundation walls are of concrete, waterproofed and coated on the exterior surfaces with stone of a concrete gray tint. The portico columns and pilasters are of brick finished with specially moulded terra cotta caps and bases, colored to match the door and window sills which are of concrete with cement finish, waterproofed and finished to conform to the color schemes of the foundation walls. All interior and exterior stepping, except in the rear porch, is of concrete, reinforced, and all floors in the excavated portions of the basements are of concrete with a waterproofed top dressing. The wards, office, dispensary, toilet, bath, serving rooms, kitchen, all halls and stairways in the first and second stories, are

This Kiowa Agency Hospital in Oklahoma was built by the United States Indian Bureau for $38,000.

*The first part of this article, dealing specifically with tuberculosis sanatoriums, was published in the July issue.

A representative Indian school hospital is the Wahpeton Hospital in North Dakota, a thirty-bed institution costing $17,960.

wainscoted with a stainless white cement and have composition floors excepting the halls, while the operating room is finished with a composition wainscoting and flooring. Elsewhere double floors are provided, the finished flooring being clear maple. The second story floors are sound deadened.

The interior finish is of No. 1 pine with head trim for doors and windows and the doors are of the simple panel hospital type. All walls above the wainscoting are plastered two-coat work, hard plaster, tinted in flat waterproof colors, and the rooms throughout are finished with a metal ceiling and cornices in patterns suitable to the size and use of the respective rooms. The gable and main cornices and parapets of the sleeping porches are of galvanized iron and the roof is covered with metal shingles. The exterior and interior painting is three coat work of best quality white lead and oil, except the wood work of the stairs which has two coats of transparent wood finish. All galvanized iron work is painted with a specially manufactured paint. The plumbing installation is in accordance with the best practice and the fixtures are of the highest grade and manufacture conforming to the government standard specifications.

The building is heated by low pressure gravity return direct and direct indirect systems and the wards are ventilated through ducts connected to roof ventilators of the air-siphon type. A modern electric lighting equipment is installed and also automatic electric bell annunciator systems.

In connection with the hospital a physician's residence, laundry building and two separate patients' cottages have been provided. These cottages are one story in height, are designed to accommodate a single family and the plan provides one large living room 16′x24′ with a rear storm shed 8′x8′ and a screened porch 8′ wide extending across the entire front of the building. The exterior walls are sheathed and finished with drop siding, and shingles are used for roof covering and gable finish. The foundations are of concrete and the living room is heated by a stove and ventilated by means of jacket vent flues placed around the smoke pipe and connected to a ventilator on the roof. The living room is also plastered two-coat of hard wall plaster and all windows are provided with screens and storm sash. The cottages were constructed under contract and cost $750 each.

Sherman Institute Hospital

The hospital at Sherman Institute, Riverside, Cal., was completed in 1912, cost $22,240 under contract, exclusive of operative equipment, but including lighting, heating and plumbing. In connection with an original building to which it is connected the hospital has a capacity of forty beds. The exterior walls of the building are of brick on concrete footings; the basement walls are faced with select red brick and the faces above the water table are finished with pebble dash; the window sills, front steps and gable window trim are of stone and the gable copings and buttresses are of cement. The main roof is covered with metal tile, Spanish pattern, and the porch roof with tin, laid with flat seams. The interior finish is of clear Shasta pine; the walls and ceiling are plastered two-coat work with hard white finish.

The hardware is best quality oxidized copper on steel and the bath, toilet and operating rooms are finished with encaustic tile wainscoting and terrazzo floors. The exterior painting is three-coat work, best white lead and oil, and two coats of transparent wood finish is used on the interior. The plumbing equipment is of the very best manufacture and type and the heating is one pipe gravity return system for which exhaust steam is utilized. The building is lighted by electricity and is equipped with automatic electric bell annunciator systems.

Some School Hospitals

The Wahpeton, N. D., school hospital was completed in 1914 under contract at a cost of $17,960 and has a capacity of thirty beds. The superstructure walls are of hard brick faced with Menominee sand mold brick backed with hollow brick and rest on foundation walls of granite faced with Lake Superior brown stone, which is also used for door and window sills. The interior finished wood work is of No. 1 pine painted three coats of best white lead and oil, the walls and ceilings generally are plastered three coat work, with paint finish and the walls and floors in the toilets and bath rooms dispensary, operating room and kitchen finished with composition wainscoting and flooring. Elsewhere above the basement the floors are doubled and the finished flooring is of Douglas Fir laid over building paper. The main roofs and front porch pediment are covered with metal shingles, and the deck and porch roofs are covered with best quality tin laid with flat seams. The hardware is of best quality oxydized copper on steel.

The building is heated by low pressure direct and indirect systems connected up to a central heating plant, is lighted by electricity and has a thoroughly modern plumbing equipment. Natural draft is resorted to for ventilation through flues, ceiling registers and ducts connected to roof ventilators.

A feature deserving special mention is the sub-drainage system which it was found necessary to install by reason of the sub-soil being an impervious clay strata. The roof drainage is connected up to the sub-drainage and collected to catch basins near the building from which the discharge is carried to the main sewer.

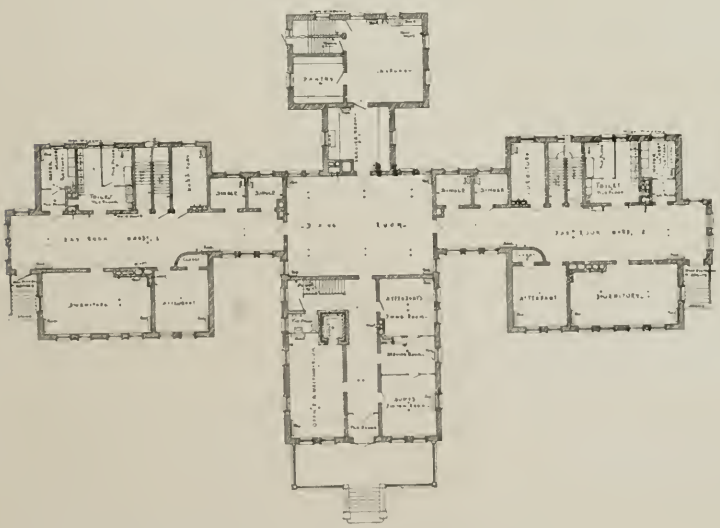
The Salem, Ore., hospital was completed in 1908 under

Hospital building at Indian Asylum, Canton, S. D.

contract at a cost of $19,978 and has a capacity of forty beds. The superstructure walls rest on concrete foundations and are built of hard brick, faced with selected red brick and laid with a two inch air space between the face brick and backing. The window sills, basement steps and copings are of stone and the exterior faces of foundation walls are finished with cement. The interior woodwork except for stairs is of No. 1 pine painted three coats best white lead and oil, the rooms above the basement except in the wards have M & B wainscoting and are finished with hard plaster, three-coat work on walls and ceilings, and the windows are finished with plastered jambs and heads. The stairs are constructed of hard wood with transparent finish, and all floors above the basement are doubled, the finished flooring being vertical grain fir. The hardware is best quality oxydized copper on steel. The roofs are covered with cedar shingles, with "Boston" hips and the ridges are finished with galvanized iron rolls. The building is heated by an individual low pressure system supplying both direct and direct-indirect heat, the latter being used in connection with the ventilation scheme which is effected through flues, ceiling registers and direct carried above the ceiling to aspirating chambers which are directly connected to ventilators on the roofs. The lighting is by electricity, the installation and that also of the plumbing conforming to the best modern practices, and being designed with special regard to hospital uses.

Second floor plan of the Asylum for Insane Indians at Canton, S. D.

The School Hospital at Moqui, Keams Canon, Arizona, was completed in the open market in 1914 at a cost of $14,000 and has a capacity of forty beds. The superstructure is of stone from quarries located near the school site and rests on concrete foundation walls. The window and door sills, lintels and frieze band are of reinforced concrete. The interior standing wood work including doors is No. 1 Arizona pine painted three coats white lead and oil and the rooms and halls are wainscoted with clear M & B pine to the height of the window stools above which they are finished with two coat work hard plaster. The ceilings throughout and the walls of the sleeping porches are similarly plastered and the ceilings of the latter are lined with M & B material. The bath and operating rooms are provided with white cement wainscoting and cement floors. Elsewhere the floors are doubled, the finished flooring being of clear maple. The building is lighted by electricity, has the best plumbing equipment suitable for hospital purposes, and is provided with direct and direct-indirect steam heating supplied from a central heating plant. Ventilation is secured through flues and ceiling registers connected to ventilators on the roofs.



First floor plan of the Asylum for Insane Indians at Canton, S. D.

The hospital plant at Canton, S. D, while listed as a sanatorium, is set apart for the treatment of insane Indians and consists of a main asylum building, a hospital building, superintendent's residence, laundry, dairy, barn, pump house, and several minor buildings necessary to the operation of the plant. The main building was completed under contract in 1901 and at a cost of $55,000 and has a capacity of forty-eight beds. The superstructure walls are of

hard brick faced with Menominee sand mold brick and laid with a two-foot air space between the face brick. All interior walls are of hard brick and all partitions are constructed of expanded metal secured to channel iron framing. The basement walls and main entrance steps, window sills belt courses, gable copings, kneelers and finials are of lime stone. All roofs and dormer faces are covered with slate, and the cornices, ridge and hip cov-

Sherman Institute Hospital was built by the Indian Bureau in Riverside, Cal., at a cost of $22,240. This was in 1912.

erings are of galvanized iron. The interior wood work except for stairs and floors, is of clear yellow pine with hard oil finish, the stair work is of oak finished with transparent varnish in two coats and all wood floors are doubled and finished with a top flooring of No. 1 polished maple. The walls and ceilings are plastered three-coat work hard plaster with float finish. The building is heated by an individual plant located in the basement and is a low pressure gravity return system supplying both direct and indirect heat, and the ventilation scheme is by natural draft through flues in brick stacks extending above the roof and topped out to conform to the chimneys. Lighting is by electricity and the installation is designed with particular regard to its uses in the building.

The plumbing equipment is thoroughly modern, and a system of speaking tubes has been installed connecting the office with the attendants' rooms, boiler room and the superintendent's quarters on the second floor.

The hospital building was built in 1915 under contract at a cost of $33,576.75 and has a capacity of forty beds.

In plan, arrangement, design, materials and construction it is a duplicate of the Kiowa Agency hospital, except that two solariums are provided instead of four. The heating, lighting and plumbing equipment are similar to those installed in the main building.

The hospital at Fort Defiance, Navajo Agency, Arizona, was completed in 1915, in the open market, at a cost of $12,600, has a capacity of forty beds, is lighted by electricity and heated by an individual low pressure direct steam heating system. All of the dimension and a large portion of the finishing lumber is of native pine cut on the reservation and shaped at the Agency Mill which accounts for the comparatively low cost of the building. The interior wood work has hard oil finish, the walls are plastered and tinted; the finished flooring is of hard wood and metal shingles are used for the roof covering.

Some Adobe Hospitals

The hospital at the Ute Mountain School, Colorado, and that at the Sells Agency, Arizona, are excellent examples of adobe wall construction with cement stucco finish and were both built in the open market, the former accommodating twenty-five beds and the latter forty. The cost per bed was $800 and $750 respectively. The lower cost for the Sells Hospital is attributed to the fact that the construction was started and well advanced before the cost of material and labor had soared to the heights attained during the past two years. Considering the accommodations provided in each hospital, their size, mechanical equipment and character of construction, the respective costs per bed must be conceded to be remarkably low, in comparison with the cost of similar hospitals constructed under pre-war conditions.

Both the hospitals are steam heated and electrically lighted and the plumbing installations and mechanical equipment are of the same excellent type described elsewhere in the article.

The interior finished woodwork in both hospitals is pine and the doors are of similar material, stock design for hospitals. The interior surfaces of all walls above the basement and all partitions are finished to the height of the window stools with a wainscoting of stainless white cement and above the wainscoting with hard white plaster. The finished woodwork and doors generally are finished with white enamel and the floors are of hard pine on maple, varnished except in the operating, sterilizing, toilet, and wash rooms which have tile or cement floors; metal ceilings thoroughly insulated are used in all finished rooms and corridors.

The close reader may criticise the use of hard wood flooring in preference to composition or similar manufactured material in these and other hospitals. Experience has proved in the Indian Service, at least, that unless the composition flooring is laid by mechanics skilled in the work it will not stand up under the use to which it is subjected and as it has been impossible, except in one or two instances, to obtain skilled mechanics, composition flooring is no longer considered as desirable for use in that service.

SMOKING ROOM FOR NURSES

Whether smoking rooms should be provided for the nurses in their residence seem to be a live question just now in England. One Mr. Tilbury, chairman of the infirmary committee of the Portsmouth Board of Guardians, resented the criticism made by a woman inspector of the nurses' home that no smoking room had been set apart for the nurses. Commenting upon the incident, *The Hospital and Health Review*, a London publication, says:

"The practice of smoking is now general among women, and few institutions object to smoking by nurses in off-duty hours, if only because such an objection could not be enforced. But evidently Mr. Tilbury was startled, not by the idea of nurses smoking, but by the formality of providing a smoking room for them.

"We all are ready to wink at practices which it startles us formally to provide for. It would be interesting to know how many nurses' homes attached to voluntary hospitals possess smoking rooms for their nurses. Such a room is desirable in the interests of those who do not smoke; and now that the practice is generally recognized, it is proper to study the convenience of non-smokers and smokers alike, which can best be done by reserving a room for those who wish to indulge in it. Since smoking entered the hospital wards during the war, it is idle to expect to exclude it from the nurses' homes."

"The fear of dirt is the beginning of good nursing."—Florence Nightingale.

WAR DEPARTMENT ORGANIZES RESERVE HOSPITAL UNITS FOR EMERGENCY USE

By MERRITTE W. IRELAND, Surgeon General, U. S. Army, Washington, D. C.

THE National Defense Act of June 4, 1920, gives a definite policy of national defense and creates the army of the United States. This army is composed of the regular army as the first line of defense, the national guard as the second line of defense and the organized reserves consisting of the officers' reserve corps and the enlisted reserve corps, as the third element or line of defense.

It is only intended that the organized reserves will be called into service in an emergency expressly declared by Congress, an emergency beyond the scope of the regular army and national guard.

Reorganize Medical Reserve Corps

While the difficulties of mobilizing the citizen army during the war is fresh in the minds of all those who participated, the Surgeon General has undertaken the reorganization of the medical department reserve corps to meet the medical needs of the military establishment in case of any emergency that might arise hereafter.

For two years classification of the personnel of the medical department reserve corps (approximately 12,000 officers), has been going on, until all have finally been divided into two grand divisions; those to serve with troop units and those to serve with medical units in the zone of combat to the home territory. The latter group has been further divided into specialists as surgeons, internists, ophthalmologists, administrators, etc. Three principles were taken into consideration in this classification; the specialty of the officer in civil life, his service during the World War and the officer's individual preference for duty. All officers in the first group have been given to the several corps areas for assignment to medical regiments and medical detachments of combat units. Officers of the second group have been retained for specific assignment by the surgeon general and with this group will be formed the following units at this time which is only a portion of the number required in case of emergency:

- 3 army medical headquarters
- 1 general medical headquarters
- 2 section medical headquarters
- 1 specialist group
- 36 surgical hospitals (former mobile hospitals)
- 45 evacuation hospitals
- 165 general hospitals (former base hospitals)
- 24 general hospitals (former camp hospitals)
- 3 convalescent hospitals
- 12 hospital center headquarters
- 12 convalescent camps
- 37 hospital trains
- 3 air service physical examining units
- 5 general dispensaries
- 3 army medical laboratories
- 12 hospital center laboratories
- 2 communications zone medical laboratories
- 1 general medical laboratory
- 9 medical supply depots
- 2 intermediate medical supply depots
- 2 base medical supply depots

The surgeon general has recently addressed a letter to each Class A medical college and general hospital approved for internship, requesting their aid in this work by undertaking the organization of one or more of the three principal hospitals, that is, the surgical, evacuation and general hospitals. It is desired that each institution will foster a medical reserve hospital of the army composed of members of its staff or of the community who are willing to become members of the reserve corps. The parent institution or none of its property is involved, but the officers designated by them will mobilize as a unit in case of emergency. The unit will in this way take on a local distinction, will pertain to the parent institution or community and will be officered by those within the institution or community subject, of course, to certain laws and regulations as pertain to appointment in the officers' reserve corps.

Will Perpetuate World War Units

The surgeon general also desires to revive and perpetuate in a general way the units that served in the World War. Former numbers are to be retained and further distinctive designations allowed. For example, Base Hospital No. 6, which served during the World War, was organized at Massachusetts General Hospital and now becomes General Hospital No. 6, the Massachusetts General Hospital Unit in the new reserve.

Hospital equipment will not be issued to the unit. The institution, therefore, will not be accountable for property and equipment in time of peace.

The enlisted reserve will not be enrolled for some time to come.

The enrolled nurses of the Red Cross nursing service constitute the nursing reserve corps of the army.

Owing to the demand on the medical department for mobilization (and no mobilization is justified until the medical service is organized) the surgeon general desires to see the medical profession of the country strongly organized to meet the policy of the national defense of the United States. Responses have been numerous and enthusiastic, but owing to the demand, it is hoped that every institution will offer to organize a reserve hospital and be prepared to contribute its share in the defense of the country.

THE INTERMEDIATE WHEEL

"One of the greatest needs I see in our social structure is of an intermediate wheel to gear together the power wheel of research and the work wheel of the practical life. In all measures that have to do with the promotion of health and the prevention of disease, properly prepared nurses should serve as the intermediate wheel. To do this, nurses must have a broad social background, and such a knowledge of the principles underlying their work that they will be able to translate them into simple language that can be made to function in the lives of all our citizens. This alone would mean a reduction of about 50 per cent of the total illness in the community, as there is abundant evidence that the knowledge we now have, if actually applied, would bring about this highly desirable result."

—Selected.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

NURSES OF THE NATION, 2,000 STRONG, GATHER AT JOINT CONVENTION IN SEATTLE

AS REPORTED BY MARY C. WHEELER, R.N., SUPERINTENDENT, ILLINOIS TRAINING SCHOOL FOR NURSES, COOK COUNTY HOSPITAL, CHICAGO.

THE biennial convention of the American Nurses Association and the National Organization of Public Health Nursing, together with the annual convention of the National League of Nursing Education, met in Seattle, Wash., June 26 to July 1.

The registration, without duplication and without many visitors, numbered 1,984, representing state nurses associations, state and local leagues of nursing education, schools of nursing, hospitals and various public health organizations.

The preparation, welcome and continued activities of the Seattle organization as hostess made the spirit of the week of meetings exceptionally fine.

Reports of the following activities were of interest:

The Nurses' Relief Fund, started in 1914, is in the hands of a special committee to examine applications and extend aid. Some forty nurses have been assisted since the last meeting. There is a need for a substantial increase in the principal, and a number of pledges from state associations, alumnae and individuals were received for this fund.

The Robb Memorial and McIsaac funds show an increasing number of applicants for scholarships.

The American Nurses' Memorial Fund, established in memory of the nurses who died in line of service, reached a total of $53,000. This was used to establish the Florence Nightingale School of Nursing, Bordeaux, France, formally dedicated May 12, the American Nurses Association being represented by Miss Sophia C. Nelson. There were several other American nurses present at the dedication exercises, which were held out of doors, and were very impressive. The president of the board presented a gold key of the building to Miss Nelson, which symbolizes the faith of the American nurses in their French sisters in the carrying on of nursing standards and ideals through their leader Dr. Anna Hamilton.

Another activity which has been developed this last year is the establishment of National Nursing Headquarters at 370 Seventh Avenue, New York City. The American Red Cross Nursing Service carried a large part of the nursing activities during the war period and now the publications, information and the placement bureau will centralize with executive secretaries. At the headquarters will also be found Miss Mary M. Roberts, coeditor of the *American Journal of Nursing*. The revised accredited list of schools of nursing, an important publication, was issued by the central headquarters, just in time for the convention. This list is as correct as possible to January 1, 1922. It gives detailed information as to the accredited schools, as well as comparative tables.

A session was devoted to reports of the American Red Cross Nursing Service, including that of the Public Health Service, the nursing services of the Army, of the Navy, and of the United States Public Health, the Federal Board of Vocational Education and the Bureau of Home Hygiene and Care of the Sick.

There has been recent legislation in New York, Missouri, Colorado, Michigan, Wisconsin, Kansas and California. There are now compulsory laws in New York, Missouri and Michigan.

Each of the three nursing organizations were concerned with changes in their by-laws. The most radical changes were proposed in the leagues considering which form of membership would be of the most value for future growth.

To Erect Delano Memorial

It is proposed to establish a Delano Memorial which will probably be in the form of a statue on the grounds of the Red Cross Building, Washington, D. C. It is believed that a statue placed in a beautiful setting of this kind would not only honor Miss Delano and her profession, but help build into the minds of those who see it the inspiration for achievement and service. Forty thousand dollars will probably be needed in addition to the $10,000 which has already been subscribed.

One of the papers which had been looked forward to for a long time was "A Recent Study of the Education of the Nurse." This was a report of the Committee on Nursing Education of the Rockefeller Foundation, Miss Josephine Goldmark, secretary, published in full on pages 1-8 of this issue. The conclusions reached in this report will doubtless form a basis for much study and self-criticism among schools of nursing, leading to better organizations by the board of directors and a broader education for the individual student nurses, who bring definite qualifications to the schools. The influence of such a report can not now be felt but after a period of ten

years or so doubtless many improvements will have taken place, traceable to this survey. Coming as it did at the end of the third day of the convention, it carried, in great measure, the summary of discussions of the preceding days.

A number of papers were presented which were of interest to the members of boards of directors of nursing schools and to the lay public. Miss Carol Martin, Chicago, presented a paper entitled "Nursing as a Profession and its Reception by the Public;" among others of general interest were: "Why the Public Should Be Willing to Contribute to the Support of Institutions for Nursing Education," by Miss Evelyn Hall, Seattle; "The Relation of Nursing Education to Community and National Welfare," by Miss Clara Noyes, Washington, D. C.; "The Ideals of the Nursing Profession for Schools for Nurses," prepared by Miss Carolyn Gray, Cleveland; "The Necessity of Gaining the Public's Cooperation for Nursing Education if the Needs of the Public Health Field are to be Met," by Dr. Richard O. Beard. Two interesting papers were given on the prevention side: "Normal Development of the Child," by Dr. William Lucas, San Francisco, and "Position Health," by Dr. Caroline Hedges, Chicago; "The Problem of the Care of the Sick Person with a Moderate Income" was a well presented paper by Mr. Richard E. Bradley, Boston, Mass.

Papers and discussions were heard as to how supplementary workers in the care of the sick could be trained. Two types of training were discussed, that given in a hospital already extending a course to student nurses, and that which consists of a preliminary course planned in one central place with the practice extended in selected institutions and houses under adequate supervision. Many points must be considered in order to protect the public, the worker and the graduate nurse it was brought out; there must be sufficient material upon which to base a curriculum; there is the element of danger in giving all available material; there is the recognized name to be determined; there is the licensing and consequent legal status to be considered. Miss Sally Johnson, Boston, presented an able paper on "Recent Development in the Training and Use of Attendants."

The executives of schools of nursing discussed many phases of their responsibility, among them the classification of schools of nursing. A paper prepared by Miss Elizabeth Burgess, New York, presented the problem. It is well known that a school having been placed upon the list of associated schools in any state does not make graduates from that school available for membership in the American Nurses Association. A definite minimum standard for membership qualification will be helped by the Rockefeller report. Close to this problem of standardization was the one of the inspection of schools from an educational viewpoint.

A paper by Miss Ada B. McClerg, Chicago, on the question of "What Nursing Education Costs" showed the necessity of a better accounting system in the nursing schools separate from the hospital accounting system and also the willingness of executives to answer the inquiries of those who are trying to study the problems which are mutually helpful. The value and need of faculty conferences of supervisor and head nurse meetings, how they should be conducted and how to make these groups more efficient in teaching was an interesting and instructive session. The instructor considered the value of preliminary mental tests for student nurses and also methods of teaching. Emphasis was placed on the need of adding psychiatric nursing, instruction in the care of venereal patients and parliamentary practice to the curriculum. The question of professional ethics was ably presented.

A number of helpful institutes were reported by different states as having been held from one to four weeks' period; these institutes may become a part of state association programs. A session on postgraduate study was altogether too short to do more than make the nurses realize that present post graduate courses are not adequate to meet the need for specialization and that schools in a position to develop special courses are under obligation to do so.

In the discussion as to student government and student activities the facts show that orderliness and system result from successful group living; that self government, with faculty cooperation, develops initiative and develops such qualifications as will stand the tests of good citizenship.

The private duty section considered the place of "hourly nursing," the private duty nurse as an educator in venereal diseases and how the prevailing tendency toward commercialism may be counteracted.

Public health workers had many subjects from many angles to bring before their group. They discussed the necessary qualifications of public health workers and their relations to each other and to the communities which they serve. In the venereal disease section were considered the present status of venereal patients and the legal measures necessary in their prevention and control.

Attention was also given to tuberculosis patients, to mental hygiene and to the administration of the Sheppard-Towner Act through the state boards of health. Visiting, school and rural nursing sections gave opportunity for advice and counsel in the handling of many difficult problems encountered in these individual fields.

Throughout the entire convention there were definite lines of thought: first, an appreciation of a kindly hospitality, of the honor of the M.A. degree conferred on Miss M. Adelaide Nutting by Yale University, of the honor of the B.A. degree conferred on Miss Annie W. Goodrich by Mount Holyoke, of Miss Goldmark's work on the survey of schools of nursing for the Rockefeller Foundation and of the excellent addresses given; second, the emphasis on prevention of illness and its after-effects; and, third, the centralization of efforts in schools of nursing to avoid waste and to offer an education in nursing to all students of nursing on a truly educational basis.

The officers elected for the American Nurses Association are: Miss Adda Eldredge, Madison, Wis., president; Miss Agnes G. Deans, St. Louis, Mo., secretary.

For the National League of Nursing Education: Miss Laura Logan, Cincinnati, Ohio, president; Miss Martha Russell, Boulder, Colo., secretary.

For the National Organization of Public Health Nursing: Miss Elizabeth Fox, Washington, D. C., president; secretarial work to be carried on at national headquarters.

FIRST SCHOOL FOR NURSES

"Florence Nightingale, the founder of modern nursing, organized the first real school for nurses in 1860 in connection with St. Thomas' Hospital in London, England.

"This school opened its doors the first year with fifteen student nurses and an endowment fund of $200,000 which the founder had received as a thank-offering from the public at large, because of her great service to humanity during the Crimean War, and which she in turn gave to this first training school."

HOW CAN WE AROUSE THE INTEREST OF STUDENT NURSES IN TEACHING AND SUPERVISORY WORK*

By NELLIE HAWKINSON, Instructor of Nurses, Massachusetts General Hospital, Boston

VOCATIONAL guidance started as a more or less haphazard effort to direct school children to jobs and to special training opportunities. It has rapidly developed from that to a study of the child's abilities and advice based on that knowledge," says Mrs. Cannon in an article in a recent number of the *Atlantic Monthly*.

We in training schools have far too frequently followed the first type of guidance. There has been a great deal of haphazard directing of young graduates into teaching and executive positions for which they had neither the ability nor the training with the result that when they found themselves confronted with problems with which they could not cope, they grew discouraged, gave up and drifted into something else. This, of course, has been largely due to the fact that the demand has been so much greater than the supply so that women with no special preparation for the work have been literally forced into accepting these positions.

However that sort of thing cannot go on. In all kinds of work more and more emphasis is being placed on getting the right man for the job. Intelligence tests in the United States Army during the recent war demonstrated the possibilities in vocational guidance. In schools, in business and in industry individuals are being tested and rated and an effort is being made to place them in positions for which they seem best suited. We also must fall into line. We must study our students more carefully, find out their abilities and try to direct them into the branch of nursing work for which they seem best fitted.

Should Study the Individual Pupil

This study of the individual pupil should begin on the day she enters the school. Instructors, supervisors, head nurses and others who come in close contact with the pupil have excellent opportunities to do this and by the end of the probation period the united observations of these various people should furnish us with a comparatively correct and fair estimate of the pupil's character and her mental and technical ability.

Of equal importance in the guidance of the pupil is a knowledge of what she is interested in, her ambitions for the future. It may be that she has very definite ideas about what she wants to do; or it may be that she knows so little about the opportunities in the field of nursing that she has given it very little thought. In either case, it would be of great help to both principal and pupil to get together and talk it over. Why wait until the senior year or, as often happens, until the day the pupil graduates and is given her diploma to find out what she considers doing? Far too frequently, pupils go through their entire training without ever having talked with the principal of the school or any member of the faculty as to what their interests are and what they would like to do. Why does this happen? Is it because the pupils are disinterested, or is it because the faculty is so "stand-offish" that pupils hesitate about coming for advice? We all know that quite a different feeling exists between the faculty and the students in colleges than in training schools. There is no reason why there should be, and if we would only do some of the things in our training schools which are done in colleges, we might succeed in creating a more friendly feeling.

For example, why not have faculty "at home" evenings on which the pupils could feel free to drop in for a friendly chat. It would be an excellent opportunity, not only for the pupil to become acquainted with the members of the faculty but for the faculty to become acquainted with the pupils. It is really pitiful how little we know about our pupils. We have so many fine women in our schools and so often we allow ourselves to become acquainted with only one small fraction of their lives. Surely, there would be nothing lost, and much would be gained if we could know our pupils better.

Having succeeded during the early part of the pupil's training in finding out her ability and what she is interested in, we should then be able to proceed in an intelligent way to help her develop her capacities and powers to the very best advantage. To test and rate the student's ability should be a comparatively easy matter, but to stimulate and maintain interest in the special field of work for which we may think she is best suited is far more difficult.

Should Have Practice in Supervision

First of all, we must remember that when students are thinking of taking up a particular type of work they are very observant of people who are doing that kind of work and are interested in finding out everything about it. So, it follows, that if we desire to have some of our best pupils take up teaching and supervisory work we must make these positions sufficiently attractive to arouse and hold their interest. We should have occupying these positions only women of the highest type whom the pupils respect and admire. Their official standing in the school should be such that it lends dignity to the position; they should be paid salaries commensurate with services rendered; their living conditions should be comfortable and homelike, and their work should not take so much of their time that they do not have a fair margin for living. These are things which must be considered with all seriousness by heads of hospitals and principals of training schools if we are going to attract to teaching and supervisory positions the type of woman whom we so urgently need.

The second thing for us to remember is something which we all learned in psychology—that to be interested in a thing means to be actively concerned with it. What we are trying to do, to interest students in teaching and supervisory work, in the school in which I am teaching, is based on this psychological principle. We are giving each year to a few selected pupils an opportunity to assist with either the practical or theoretical instruction. These pupil assistants help with the supervision of the probationers' practical work on the wards and in the classroom; conduct quizzes under supervision; assist in the laboratory work in connection with the sciences; help in correcting papers and notebooks; and, if the assistant is an exceptional pupil, she may be given the opportunity to conduct an occasional class.

In following this plan, however, there are two points

*This paper was read at the recent Alumnae Meeting of the Department of Nursing and Health at Teachers College, Columbia University, New York, February, 1922.

which must be carefully and thoughtfully considered. First, the pupil assistants must be selected on a basis of character, mental ability and technical skill. Only those rated in Group A should be assigned to this work. This is important, not only because teaching and supervisory work require these qualifications but also because these assistants are working almost entirely with the entering students whom, we know, are most impressionable.

Must Not Exploit Assistant

In the second place, the work assigned to the pupil assistant must be well planned and supervised so that she will profit from this experience. Great care needs to be exercised to prevent this from developing into another form of exploitation, another way of getting work done with little expense to the hospital. It should be carried on entirely for the pupil's benefit and not to assist in swelling the funds in the hospital treasury by saving the salary of a paid graduate assistant. The express purpose of it should be to give the pupil a chance to become acquainted with teaching and supervisory work and to try herself out under careful supervision. What she gains from this experience must necessarily rest largely with the way the work is planned and supervised.

There are two questions which I know have already arisen in your minds. The first is: Have we succeeded in accomplishing what we hoped to, that is, have these pupil assistants become sufficiently interested in the work to "carry on" with it after graduation? Of those five who have assisted in the theoretical teaching since we started this method, three have definitely determined to take up teaching, one is doing head nursing and the other is still undecided. In the department of practical instruction there have been at least thirty-five assistants. Of these, we know definitely that twenty-five have taken up either teaching or supervisory work. I think this is conclusive proof that some such method as I have suggested does help in arousing and maintaining the interest of the pupil.

The second question is: Will such experience make students feel that they are sufficiently prepared to teach and so discourage further study and preparation? I think I can say emphatically, NO. All five of the assistants whom I have had, three of whom were college graduates and one having had two and one-half years of college work, have all expressed the same feeling, a realization that their preparation is insufficient and that further study is necessary. Three of the pupil assistants whom we have had this past year are planning to go to Teachers College this fall, which I think helps to support the statement I have just made. Of course here again the instructors with whom the pupils are working can do much or little to encourage further preparation. Two others with whom I talked recently want to go but feel that they cannot afford it. This is where one or two scholarships for further study could be well invested.

In closing, there is one question I should like to ask and I hope it will be answered by some of you in the discussion. Why could we not have during the last year an elective course in teaching or supervisory work as we have in public health nursing; a course where the theory and practice of teaching or supervision could be combined? While much has been and is being done to direct pupils into public health work most of us have been sitting back with folded hands doing little or nothing to arouse their interest in supervision and teaching. Please do not misunderstand me and think that I am unsympathetic with public health nursing. I realize the importance of it as you all do, but I also realize that we need to keep a few of our fine women in our training schools in teaching and executive positions if we are going to graduate nurses who will be fitted to carry on this great work of health education and prevention.

MISS NUTTING RECEIVES AN HONORARY DEGREE FROM YALE

Yale University at its Commencement exercises on June 21 conferred the honorary degree of Master of Arts on Miss M. Adelaide Nutting, one of the deans of nursing education in America. Miss Nutting was the only woman among thirteen men to be so recognized at the June Commencement.

Miss Nutting's association with Johns Hopkins University in the early years of its school of nursing brought her into prominence. There she emphasized the educational nature of nursing training and through her efforts, there became incorporated in the system of nursing education many of the distinctive features of professional schools.

The first nurse to be appointed to a chair in any university was Miss Nutting when in 1907 she went to Columbia to organize a department of household administration. The department became known later as the department of nursing and health and with it Miss Nutting is still associated.

As chairman of the Committee on Nursing under the Council of National Defense during the World War, Miss Nutting added another worthy contribution to her country and her profession.

In introducing her for her degree, Prof. William Lyon Phelps of Yale addressed Miss Nutting as "one of the most useful women in the world."

Mental patients should be remunerated for their work in the hospital, in the opinion of Dr. Nelson H. Beemer, superintendent of Ontario Hospital. He believes such a system would be educative, would increase production and decrease destruction.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

THE ORGANIZATION OF A SPECIAL METABOLIC AND DIETARY SERVICE

BY AMALIA LAUTZ, DIETITIAN, PRESBYTERIAN HOSPITAL, NEW YORK.

TREATMENT of disease through diet has been carried on in hospitals for many years in a somewhat haphazard manner. Gradually, attention has become focused upon this branch of medicine. With the development of biochemistry, dietotherapy has attained an apparently sudden and compelling prominence. The evolution of specialized dietary work within the institution has gone through successive steps of invalid cookery, division of hospital meals into house, soft, and liquid diets, until finally the increasing number of cases, not falling into these classifications, has been gathered together in diet kitchens under the head of special diets. Disturbances of metabolism, as in diabetes or nephritis, call for most meticulous and individual attention to food, not to speak of numerous other diseases and conditions as, for example, those of the gastro-intestinal tract.

"In starting a department at the Presbyterian Hospital, New York, and in working out our problems from day to day," writes Miss Lautz, "we have become more and more strongly convinced that activity, energy and initiative are offered an ever widening field in a metabolic and special dietary service. The disquieting feature in the organization of such work is not in the limitations of mere meal-getting, as many might imagine, but rather in the difficulties of realizing our visions and of developing such a department to its fullest possibilities. A dietary unit of this kind properly organized and extended can be one of the most vital, useful, cooperative and worthwhile departments in the hospital. It has a broad scientific, educational and social function. It may and it ought to bring a real contribution to the service of mankind and to the evolution of medical science and skill."

In so new and undeveloped a field where procedures are practically unstandardized and without precedent a pioneer attitude is essential for the dietitian. Unless the need for such work has been keenly experienced by physicians or the public, interest in dietetics may be uninspirational and the lack of it most discouraging. Difficulties of inadequate equipment and unsuitable working space may present an aspect of unsurmountable importance.

The dietitian interested in the specialized field has many points of contact in the hospital, such as the administrative staff and its employes, the medical staff, and the school of nursing. Cooperation is absolutely essential for the development of a real metabolic dietary service, and it is only through cooperation from all concerned that at the Presbyterian Hospital it has been possible, despite disadvantages of the geography and equipment of an old hospital, to begin the organization of a department of nutrition which it is hoped will develop into a truly therapeutic, educational and scientific service.

In planning a specialized dietary unit attention must first be directed to the divergence of its problems from those of the main hospital kitchen where food is issued in bulk to patients and employes. There the finding of an average well balanced food ration for large groups of people, economy of food materials and labor, efficiency in amount of output, and the use of specialized metabolic dietary department a number of other points rise immediately for consideration.

As every phase of this field is developmental, open-mindedness and an appreciation of the research method of work cannot be overestimated. The procedure is that of the laboratory with a laboratory kitchen equipment rather than a commercial one with the object of a maximum output of food. When food values are calculated and patients listed individually, records of cases and figures automatically become a necessity.

Cost per person, unfortunately rises apparently unduly where expensive food products or special substitutes are a part of treatment, and this rise in per capita cost may cause temporary panic in hospital administrators. The diet must be suited absolutely to the disease. Certain foods may become more essential than drugs and the lack of them may mean failure in treatment for physicians and dietitians, as the lack of suitable instruments may mean failure for the surgeon. Then too, with all the theoretical nutritional knowledge that it is possible to accumulate, lack of study of the individual's food idiosyncrasies and an inability to suit him may raise the death rate.

Bound up with its daily food service, a specialized dietary department has an opportunity for wide educational functioning. Pupil nurses and pupil dietitians compose the large part of the working force. Here the

nurse receives her practical instruction in one of the most important branches of her profession. Dietitians are trained to take up the direction of similar departments in other hospitals or to go into allied branches of food work. Patients must be instructed so that good results obtained under treatment may not be lost in a few short weeks or days of ignorance or carelessness. Medical students can well benefit by observation of actual dietaries. Even the physician with his fund of knowledge may be aided in an otherwise disconcerting moment by an ability to visualize grams of protein, fat and carbohydrate in definite food materials.

Where the staff is really interested in nutrition, special therapeutic cases may become research cases as well. New diets must be continuously evolved as well as new methods of getting into these diets the precious grams of correct food value. In organizing our department, we have found it necessary to work out and determine upon many new recipes as few special diet formulas fitted into our diets without change or adaptation. Invention could not stop here as equipment for the average home or institutional kitchen was frequently unsuitable. Had we not supplemented it by specially designed devices, individualized weighed meals would have swamped the department. It is obvious then that an unbiased adjustable point of view is a requirement for dietitians interested in this field.

In the laboratory method of work food must be accurately weighed, records and charts must be carefully kept and all unavoidable errors indicated. Supervision of charts and weights must be continuous. Every article on a tray must be literally checked off or diet calculations amount to nothing. Cooking procedures should be so planned that all food value is preserved as far as it is possible to do so.

Planning Quarters in a New Hospital

In a new hospital with the possibility of planning space allotment ideally, the problem of running a department is very much lightened. Under such happy conditions a large central diet kitchen with adjoining office and storeroom can be provided for calculation, weighing and preparation of all therapeutic diets. Ward kitchen space for diet nurses under the supervision of the dietitian can be arranged. Diets may be sent out cold, the heating and service of them becoming an extension of the central diet kitchen work for the ward diet nurses. In a smaller hospital, with a large diet or metabolism kitchen, all diet nurses may be gathered there and trays be served hot directly to the patient by the same nurses who prepare the food.

The cold method of issuing diets is less accurate but reduces work and personnel, cuts down service and dishwashing within the diet kitchen, allows heating and charting on the ward, and saves many trips between diet kitchen and ward, often at a great distance from one another. Consequently, it reduces the number of student dietitians, nurses, maids and porters delegated to dietary service. While the method of serving trays hot from the centralized kitchen is infinitely more accurate and more satisfactory to the patient, it requires, not simply more nurses within the diet kitchen, but a greater number of diet nurses because of the time spent in transportation of food and trays and in necessary trips in order to supervise and serve the diets on the wards.

A metabolism ward with an adjoining kitchen and laboratory is really essential for the therapeutic metabolism cases under special observation. Only by gathering such cases into a special ward, where mechanical facilities to promote accuracy are conveniently arranged, where dietitians and nurses preparing food can be in close contact with the patients receiving the diets, and with the laboratory where tests are made can the best results be obtained. Then the patient, the food, the charts, the specir ens can be supervised with that minimum of physicial and mental effort which encourages good work.

The Plan at Presbyterian Hospital

In working out the problem at the Presbyterian, we have at our disposal three small connecting diet kitchens separated by a storeroom and one by a passageway so narrow that tradition has handed down the story of a stout nurse who was unable to go through. An office is located diagonally across the hall.

Two small connecting kitchens, we have assigned to the work on general therapeutic diets together with preparation of any special high caloric soups, beverages, modified milk preparations, or extra foods called for on the wards. These kitchens serve to give the required diet kitchen experience to pupil nurses. In them student dietitians in training aid in supervision.

The third diet kitchen, separated by a storeroom and the narrow passage, we have set aside for the preparation of twelve very special metabolism diets allotted to twelve metabolism beds grouped and somewhat separated from the general medical wards, and under the care of a cooperating metabolism head nurse. In this special laboratory-kitchen student dietitians and one selected senior nurse do all the actual preparation and charting of food and most of the calculation.

The connecting storeroom is drawn upon by both groups of workers and refrigerator space is allotted to each group for small trays of food already weighed. As there is no space on the wards for service of weighed diets, all these are sent out hot and served directly to patients by nurses and students from the dietary department. The separation of the working space is a great disadvantage. The need for supervising dietitians is actually doubled as a dietitian must be present in each division during the most strenuous working hours.

General Working Methods

We have evolved the following general working method: Prescription blanks are collected daily by dietitians on ward rounds following the regular morning rounds of the physicians. According to these prescriptions rough estimates are made. The food calculated is divided into meals, and entered on the right hand side of a food chart which has two carbon copies. The lower carbon is then removed, folded over and additional working directions are noted. It is given in the afternoon to the nurse and pupil dietitian as a working sheet from which to weigh the next day's diets. This enables the commencement of preparation without a delay in waiting for the final checking of the figures by the dietitians and saves verbal directions. On this working sheet food returns are noted. Alterations made subsequently in the diet are written in. The dietitian goes over the menu, and totals the various foods used. On the left hand side of the chart with its remaining carbon copy, she records these total amounts to insure against error in the division into meals. After comparing the totals with her original rough estimation, she fills in the food values for each amount of food substance, adds the total protein,

fat and carbohydrate, comparing her results with her first calculation. If the totals agree her work checks and she puts aside the chart for any notes on fluid or food returns to be made at the end of the day. If the totals disagree, she finds her error, corrects it on her chart, and on the weighing sheet given to the nurse. At the end of the day the weighing sheets are turned in. All returned food and re-calculated foods are noted on the chart, together with fluids taken during the day. The top copy is sent to the ward on the following morning and serves as a ward food chart. The complete carbon copy is filed in the department for future use and as a record of the case. With carbons of diets for diabetics and those of cases in the special metabolism beds, a laboratory chart is kept and filed as well.

In records of food used as a basis for research or publication, checking by more than one person cannot be too strongly emphasized. All original figures legibly arranged with sources specified should be preserved. If it is possible to keep them in a bound notebook, rather than in one of the loose-leaf type, such records are much more satisfactory, as the loss of single pages is eliminated. In checking by the second person a definite check mark should be used. Copied figures are apt to slip by and need as careful going over as new calculations.

In preparing the meals according to her carbon copy of the chart, the nurse or student weighs out the raw materials, cooks what is needed and sets aside food that is to be served cold. Breakfasts are weighed at night to insure a careful and prompt service in the morning. Supper diets are weighed before going off duty at noon, so that the afternoon work consists of cooking and serving the supper diets, charting the foods and weighing the breakfasts. In order to preserve food value cooking is done almost entirely in dishes used for tray service as well. Cookery processes are usually baking, steaming and broiling.

Keeping Equipment to the Minimum

In planning equipment the fact that most of the food is to be cooked individually rather than in bulk is one of the first difficulties. Before beginning to get anything new, all old and unnecessary equipment should be eliminated. We found this cutting down a great help in running a department where people change continuously. Thought in planning to do without the unessential and in keeping the type of equipment simple enough to be properly cared for helps enormously in promoting working facility. Stove space was enlarged as it must be adequate and not crowded to insure good results where many people work at the same time.

For preparation of diets each nurse or student has a separate table. Over the table are narrow shelves on which the worker can place her small labelled individual storage trays, one for each patient, which are used to hold food to be subsequently cooked and to be placed cold in the refrigerator until meal time. A row of brass hooks on the edge of the shelves serves to hold the weighing sheets, odd recipes, or cards of direction and to keep them out of the worker's way. A routine or plan of work is posted over each table to do away with unnecessary verbal instructions. Brass name plates for marking large and small trays, the storage shelves, and the outside of the refrigerator have proved extremely practical. Gram scales of spring type with adjustable dial reduce to a minimum the irksomeness of weighing. When used together with balance scales for the determination of small amounts, with care in adjustment, and constant and systematic checking with gram weights, results, we feel, are reasonably accurate. The moment such scales show the slightest mechanical defect, we return them to the manufacturer for adjustment. Two or three extra scales are kept on hand to fill in the gaps made by repair periods.

Green and white custard cups in two and one-half, five, and ten ounce sizes, individual casseroles, petites marmites and tea pots with some glass baking dishes are attractive and practical. Breakage is, of course, always a difficulty, but with constant care and extra covers, cost can be much controlled. The advantage of preservation of food value and conservation of heat, together with saving of hours of labor in dishwashing without loss of attractiveness, in a great one. It pays to work out a system of cooking and serving in the same dishes. An upright steamer with removable baskets which can hold a number of casseroles and cups, large baking sheets to facilitate removal from the oven, a large hot water bath with a rack on the top of the stove, make for ease in cooking and handling. The usual china marking pencil of the laboratory preserves identity. Aluminum cans ranging from one-half pint to a quart, with covers attached by chains easily tagged have proved valuable for the distribution of cream soups, broths or cocoa to be given on the ward.

With the joy of a cold storage room, the placing of perishable supplies and of foods already weighed becomes almost a pleasure; it is a pleasure, however, which one in an old hospital must forego. We have found, however, that very large refrigerators with many small shelves for holding the storage trays and raw supplies are a good makeshift. Large size wire desk letter baskets serve excellently to keep apart the various small amounts of fruit and vegetables required for individualizing diets and are inexpensive.

Many times it was impossible to purchase labor-saving devices. In order to produce what we needed or to save expense it was necessary to take ruler and pencil in hand. Work tables, thirty-six inches high with shelves underneath which fitted into exact spaces in the laboratories, were made in the hospital workshop according to specifications. A cupboard to take all the equipment for baby formula work was fitted into a limited space on the children's ward. Dishwashing tables on rollers to fit under drain boards were designed. Chart racks were squeezed into available corners. Removable wire baskets to fit into straight kettles aid in the thrice cooking of vegetables. Square wire broilers to fit over casseroles enables a complete preservation of food value when meat is broiled, and increase accuracy preventing the mixing of different weights of meat on a common broiler. Individual round wire baskets for steaming vegetables are frequently useful, and it was necessary for us to design the hot water bath fitting an entire stove section. A bran washer, an oblong wooden frame with a fine wire mesh rack covered loosely by several layers of cotton, reduces the manipulation of bran washing to occasional stirrings, and so expediency becomes the mother of invention.

The arduousness of calculation has been lessened by food tables of market supplies used, calculated into amounts of five to one hundred grams. As the figuring is reduced largely to the process of addition, small adding machines play a most helpful part. In calculation of calories, in checking of substraction and division, a slide rule saves time and increases accuracy.

Prescription blanks with name, diagnosis, diet, desired food values, signed by the physician, serve as a record of

orders. Spacing to allow for a series of prescriptions for successive days with a possible comment of "unless sugar appears in urine" or "if sugar free" saves the physician's time and enables the dietitian to proceed without waiting for another order.

A large wooden bulletin board with metal card holders arranged according to service divisions, we have found much more practical than a blackboard for keeping the daily record of cases receiving special diets. Any card can be withdrawn at will and the number and distribution of cases can be seen at a glance.

Individual manila folders containing carbon records of calculations together with the prescriptions for each case are filed alphabetically. These folders are kept in a large indexed cardboard desk file while cases are active. In this way they are easy of access. When the case is dismissed or discontinued the original copies on the food chart are incorporated with the regular ward chart and filed in the record room. The carbon duplicates and prescriptions in their folders are filed permanently in a large steel file in the dietitian's office, and so are easily available for future use in the department, either for returned patients or for studying and gathing of data. In addition, the department files in detail all business papers, catalogues, pamphlets, etc. Cards in small wooden desk files in with names, wards, and diets of patients and divided into likes and dislikes. These cards are taken to the ward where dietitians interview patients, and food preferences or prejudices are noted on them. They can be conveniently used when the diet is to be calculated.

In the choice of foods the dietitian in charge of special diet work has opportunity to cooperate with the buyer of the institution. It is usually possible to plan most of the diets using simply the ordinary food supplies purchased by the hospital. A fairly standard supply list can be worked out and a knowledge of fruits, vegetables, etc., coming in according to season will serve as a basis for calculation. Actual individual therapeutic dieting, however, is not comparable with mass feeding. In many cases through diet the patient gets his only hope of life. Food and food substitutes must necessarily be unusual. Forty per cent cream for high caloric diets, tender cuts of meat, egg whites, mineral oil, agar-agar are necessary directly for treatment. Cost cannot be compared to that for the patient on a regular hospital diet. The special diet may be taking the place of both medicine and surgery in a particular instance.

In order to achieve a successful dietary which suits the disease and the variation of it according to the case the dietitian must cooperate absolutely with the physician. She cannot simply be a machine, situated remotely in unknown regions from which emerge on order meals for dangerously sick people. The untrained dietitian or the dietitian with the wrong attitude can cause enormous havoc. In treating disease a little knowledge is indeed a dangerous thing. The greatest possible alertness which it is possible to muster and continuous study are really needed if the dietitian is to keep abreast at all with cases or methods of treatment. She must of course have a good background of chemistry, nutrition and physiology. In addition, she must have opportunity to see the patients, consult with the physician, receive an explanation of prescriptions and cases, if she is to do her best work. She must learn to interpret charts. She ought to get into the laboratories to follow the results of her work.

We have found ward rounds most helpful, and it has been gratifying to have various physicians give their time to the explanation of cases not only to the dietitians, but to groups of student dietitians as well. Of course, no matter how interested the attitude of the dietitian she can do little if the physician does not care to cooperate with her. In cooperating her work and records must be always available; possible errors discovered after a diet has been given must be recorded on the chart. With research work this cannot be emphasized too strongly.

Simply suiting the case from a medical point of view may be a failure if the patient's taste is not taken into consideration. Here enters the bugaboo of individual differences, which so complicates any institutional care. Nationality, food habits acquired in childhood, sex, station in life, appetite, ideas fallacious or non-fallacious vary the request and must be studied. One patient will take orange juice, while the person in the next bed wants the pulp. Cream or vinegar with spinach may balance the scale in favor of the entirely consumed meal. A dish of spaghetti or a slice of rye bread at the right moment may mean a willingness to cooperate dietetically during an entire stay in the hospital. A working man may enjoy a great bowl of meat and vegetable stew, while the patient in the private room prefers a bit of chicken breast and a dainty salad.

While it is impossible in every instance to heed all requests, often a choice of meats, cereals or vegetables means happiness or unhappiness to the patient and success or failure in treatment of the case. One patient may be most comfortable with a good deal of bulk in the diet. Another requires concentration. A third has had his teeth removed and has a sore mouth. It is just as easy to calculate a diet into fluids for a day or two rather than into bulky vegetables and fruits. Often we have found that a patient with no appetite will take his full allotment of protein, fat and carbohydrate in fluid form until he begins to feel hungry when bulk can be gradually introduced, food values remaining the same. With reasonable attention to individuality and an observance of not too exotic and unaccustomed a variety the hated special diet may become a boon to the hospital sojourner.

In addition to food tastes of the patient we have found the psychological factor a big one with which to reckon. Trays should be as attractive as time and money allow. Psychologically, the visiting of the dietitian has a good effect. The patients feel that someone is really interested. They know that complaints have reached the right source. Frequently they tell us, "I am glad I spoke because it's been changed." Often an explanation of why certain foods are included or excluded in a diet, a light touching on inevitable differences between home and institution will induce a patient to take a diet. I can recall definite instances where two or three patients on medical service

THE 1922 CONVENTION.

Preliminary announcement of the program for the 1922 convention of the American Dietetic Association to be held in Washington, D. C., October 16-18 is made in the Department of Meetings, Conferences and Conventions on page 176 of this issue. To the interesting list of speakers mentioned there, others of note in the world of dietetics and related fields are being added week by week. The final program will appear in a later issue of THE MODERN HOSPITAL.

were returning food. After one visit each patient began to eat entire meals of the same food. Visiting need not be irksome. We combine it with ward rounds, covering a certain group of patients every two or three days and within a week seeing all. New patients are interviewed as soon as possible after their admission or delegation to the nutrition service.

One of the biggest, most worthwhile and decidedly fascinating opportunities of a real department of nutrition lies in its educational function. The dietitian takes charge of the actual classwork in dietetics given to the nurses. In the diet kitchen the pupil nurse receives her training in practical food preparation. It is for this reason that in our metabolism diet kitchens we have graded the work for the nurses, letting them pass from one table to another with a definite assignment at each.

The nurse starts at Table I with a preparation of foods and food substitutes cooked in larger quantities as washed-bran biscuits, agar jellies, high caloric cream soups and cocoas, thrice cooked vegetables, junkets, odd orders of peptonized milk, etc. called for by the wards. At Table II she begins with diets in which calories only are calculated. At Table III she is allotted special high caloric and salt poor low protein diets, and she passes on to Table IV where the work for diabetics is grouped. During the final week of her stay under the dietitian she prepares formulas on the babies' ward, relieves the nurse at diet tables and helps with the charting and verification of calculations, is responsible for the entire weighing, preparing and serving of food for the cases assigned to her other than the preparation of foods taken care of at Table I. With the opportunity of serving her own diets directly to the patients her contract with the ward is never completely broken during the training in the diet kitchen. I feel that since the nurse in her use of practical dietetics will care almost always for the individual patient and since variety in cases gives her all the usual wholesome dishes to prepare, such skill will be much more useful to her than a so-called diet kitchen training where most of her time is spent in turning out the customary hospital custards, jellies, desserts and salads in enormous quantities. We feel that in a graded diet kitchen training as we give it, together with class work and ward experience, the student nurse gets a good all-round elementary knowledge of practical dietetics. To the special therapeutic research division only one selected senior nurse is assigned for duty.

Student dietitians in our department with the exception of certain university students working for graduate credit —who spend two months in intensified metabolic work— go through the kitchens given over to general therapeutic work, through the special metabolic division and through the work on the baby ward. We try to start them in the general division. Here pupil dietitians begin like the pupil nurse, doing the work with the nurses passing from one table to another, but proceeding more quickly. They then begin to assist with supervision aiding the dietitian in checking over the trays and in verification of diets. Gradually they learn the needed calculations, beginning with cases calling simply for a definite caloric amount and then going on to those in which all food values must be worked out. They note the possible returns on trays, visit the patient and supervise service. The result in most cases is dietary skill shown by an ability to make the patient eat, thus doing away with that most futile of occupations, only too common in hospitals, the calculation and weighing of many diets day after day which the patient barely touches or even refuses entirely.

The preparation of baby formulas rounds out the training. Helping with requisitioning, general routine and supervision develops executive ability. In the special metabolic division the student dietitian has opportunity to progress still further. She continues the development of her skill in calculation, preparation and meal planning, that development which through studying the recipient will always aid her in whatever food work she may do later on. Here, if she has inclination, she can cultivate the attitude of research which will help her in working out problems of her own. She sees the laboratory charts and is daily on the wards in contact with the patient.

Once a week dietitians and all pupil dietitians meet for discussion of cases and problems with or without the help of a physician. A small library of medical and dietetic books and magazines is maintained in the dietetian's office to which dietitians and nurses can go for reference or from which they can take reading matter over night.

In the teaching of medical students a dietary department has opportunity to make theoretical instruction more concrete. We have provided lecture demonstrations and have actually taken classes through the diet kitchens. The observance of diets prepared can help much in later years given over to prescribing food as well as medicine. Possibly, this may do away with the small basis of fact which underlies the tales whispered by one dietitian to another, one of which runs a little as follows: A young physician prescribed a diet containing 400 grams of protein with a minimum of fat and no carbohydrate. He complained indignantly to the dietitian because the patient did not take the food. He was so earnest in his scientific endeavor that on invitation he repaired to the diet kitchen to eat the diet himself. The only necessary comment is that the prescription was changed without further discussion.

We have been called upon to prepare demonstrations illustrating, for example, the relative carbohydrate content of food, even for special lectures given to groups of physicians who surely have a practical knowledge of the kind and amount of food needed to give the nutritive values which they prescribe.

In the educational work of the department the patient must not be forgotten. Treatment in the hospital except in acute conditions is merely a stop-gap. Patients who must continue to diet after hospital discharge ought to receive instructions in food preparation and calculation while on the ward, and then in the diet kitchen when they are able to come to it. In the dispensary, dietary teaching must be continued or inaugurated. Ideally, the individual instruction is linked with class work, food demonstrations and follow-up work into the home, to insure to the patient a practical understanding of the diet and a proper adjustment of it to his environment. A little of this work we have begun, but most of it we are hoping to develop in the near future.

In starting the department at the Presbyterian and in working out our problems from day to day we have become more and more strongly convinced that activity, energy and initiative are offered an ever widening field in a metabolic and special dietary service. The disquieting feature in the organization of such work is not in the limitations of mere meal-getting, as many might imagine, but rather in the difficulties of realizing our visions and of developing such a department to its fullest possibilities. A dietary unit of this kind properly organized and extended can be one of the most vital, useful, cooperative and worthwhile in the hospital. It has a broad scientific, educational and social function. It may and it ought to bring a real contribution to the service of mankind and to the evolution of medical science and skill.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

THE HEATING AND VENTILATION OF ST. JOSEPH'S HOSPITAL IN KANSAS CITY

BY WALTER E. GILLHAM, CONSULTING ENGINEER, KANSAS CITY, MO.

THE St. Joseph's Hospital, Kansas City, Mo., was designed and built by Messrs. Wight & Wight, architects of Kansas City, Mo. during 1915-1916. It is fireproof throughout, of reinforced concrete and steel, red mat face brick and terra-cotta trim. The building is in the form of an elongated X, the four wings, 85' x 39', extending out from the main body of the building at an angle of about 22 degrees. The main body of the building is the administrative portion; in the wings are located the patients' wards and rooms; the operating rooms are located on the top floor in the northwest wing.

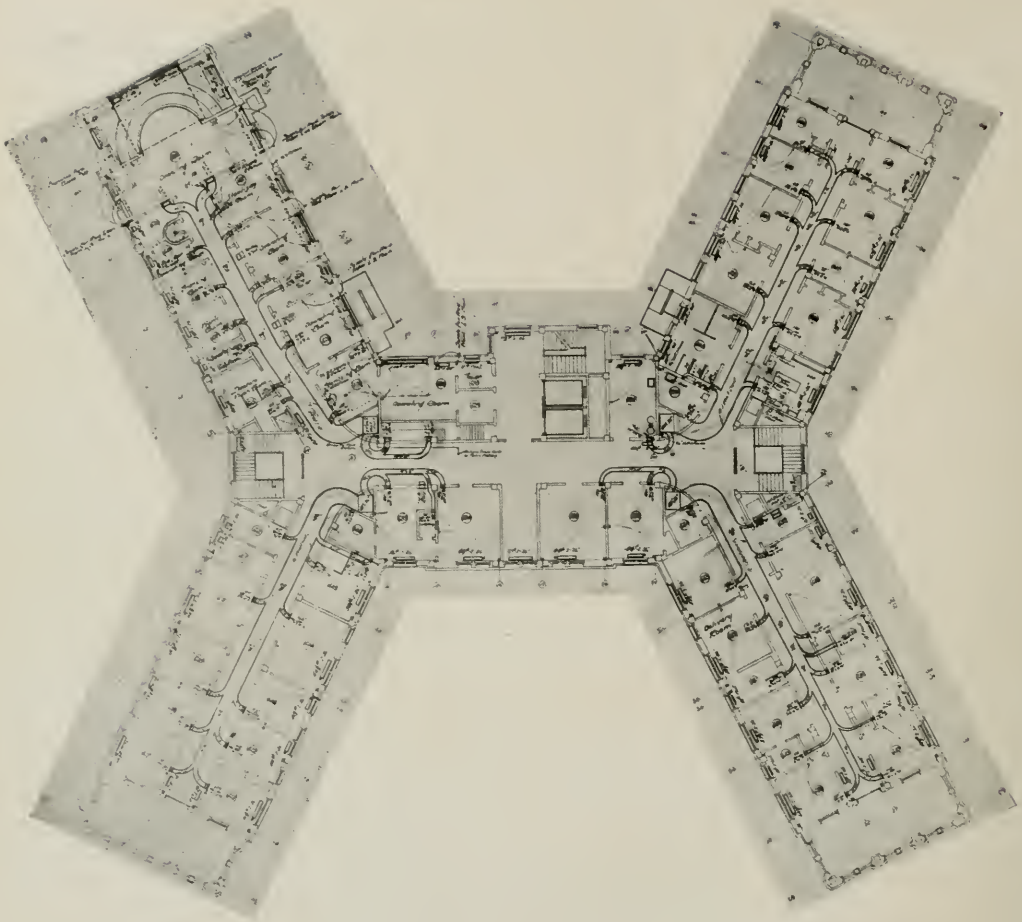
portance. Beneath the ground floor is a tunnel floor. The tunnels are about 8 feet wide and 10 feet high and extend through the center of the main building and to the end of each wing, they are used for heating, plumbing and refrigerating piping and electrical conduits. From the northeast wing the tunnel extends underground to the boiler house and laundry, a distance of about 100 feet. It is used as a passageway between the building and boiler house and is of such size that laundry carts or trucks may be conveyed through to the laundry.

The boiler house is located on the northeast corner of

The St. Joseph's Hospital of Kansas City is built in the form of an elongated X.

The main entrance faces south on Linwood Boulevard, one of Kansas City's most beautiful thoroughfares, and the building, with boiler house, occupies the entire block from Prospect to Wabash and 31st Street to Linwood. It is expected that a nurses' home will be erected sometime in the future on the northwest corner of the block. The building is seven stories in height including the ground floor which is occupied by the kitchen, dining rooms, lecture room, chapel, examination rooms, drug room, lounging room and various other rooms of lesser im-

the block; three 200 H. P. water tube boilers in basement furnish steam for both power and heat. The boilers are steel encased, set in one battery and built for a working pressure of 150 pounds and operate at a working pressure of 135 pounds. The boilers are fired by means of oil, there being installed under each boiler an efficient oil furnace. A test made at the time of installation, under operative conditions, shows an evaporation of 16.25 pounds of water per pound of fuel oil. Two 8' x 32' steel oil storage tanks are buried in the



Heating plan of sixth floor of St. Joseph's Hospital.

ground on the outside of the building and the oil is fed to the burners in the furnaces by means of a twin set of duplex oil pumps.

There is located on the same floor level as the boiler, two 500 H. P. boiler feed pumps, one 500 H. P. feed water heater, two vacuum pumps of such capacity that either pump will handle the condensation from the entire building, two six-foot filters, one 5′ x 12′ water storage pressure tank and two water pumps.

The electric current for light and power is generated by means of one 100 K.W. direct current generator driven by a direct connected simple engine and one 150 K.W. direct current generator driven by a direct connected Corliss type engine. Both units of engines and generators were built by the same manufacturer and are located on the ground floor level. There is also located on this level of the boiler house the refrigerating and ice making machinery. The second floor of the building is occupied by a very complete and up-to-date laundry.

The exhaust steam from the engines furnishes heat for practically the entire building and the gauge on the low pressure main seldom registers more than one pound pressure. The exhaust steam from engines passes through the feed water heater, from there to the low pressure main. The excess steam which is not required to heat the feed water or for the purpose of heating the building is discharged to the atmosphere through an efficient back pressure valve.

The steam for the heating system of the building is taken from the main high pressure boiler header through a seven-inch line on which are located two pressure reducing valves, one reducing the pressure of the steam from boiler pressure to sixty pounds, the other from sixty pounds to zero. Both valves are bypassed and from the bypass around the last valve a line of pipe carrying steam at sixty pounds pressure is run through the tunnel to the main building and to the attic space of the building; from this line branches are run supplying steam to all sterilizers and cooking apparatus that require steam at this pressure. From this main there is also a line of pipe taken through a pressure reducing valve which supplies live steam to certain radiators located in operating rooms,

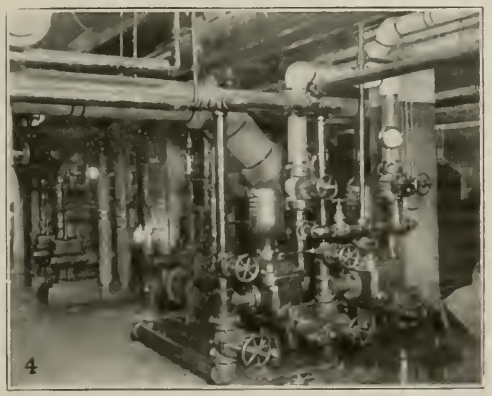
etherizing rooms and rooms in the obstetrical ward. The radiators are for the purpose of heating these rooms on cold, chilly days during the spring and fall when heat is not turned on the entire building.

A ten-inch low pressure steam supply main is run through the tunnel to the main building, up to attic, branches to the various risers and supplies steam at low pressure to the entire building. Each branch to a riser is valved in the attic with a corresponding valve on the return riser in the tunnel, so that each pair of supply and return risers may be cut off for repair or removal of radiators. All rises are concealed in wall chases and no exposed piping is seen in the rooms except the branches to the radiators. Each radiator not automatically controlled is equipped with an easily operated packless radiator valve and there is also a return trap on each radiator. The same trap is used on the drip from steam risers to the return main in the tunnel. The condensation from the low pressure heating system is returned by means of piping in the tunnel to the vacuum pumps in the boiler house, and then to the boiler feed water heater when the temperature is raised by means of the exhaust steam to 212 degrees, then to the boilers by means of the boiler feed pumps. The condensation from the live steam radiators and from all sterilizers, cookers, etc., is returned by gravity direct to the feed water heater.

Elevation of the boiler house.

Ventilating System

The ventilation of the hospital is accomplished by means of the exhaust system only. Two exhaust fans, handling 35,000 cu. ft. of air per minute each, are located in the attic at a point where the wings intersect the main building. Each fan is driven by a slow speed direct current ten H. P. motor directly connected to the fan shaft. The fans are entirely enclosed in the exhaust air chamber to which the galvanized iron exhaust ducts are connected.

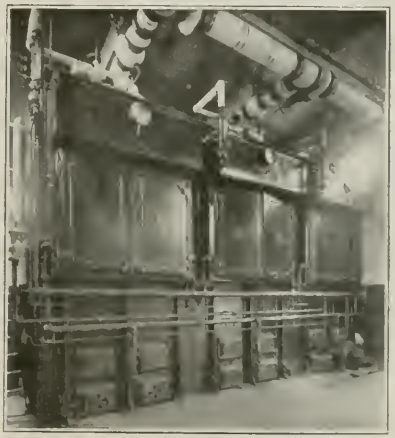


Boiler feed and vacuum pump at St. Joseph's Hospital.

There is no direct connection between the fan inlet and ducts, and thereby all possibility of the galvanized iron ducts carrying the noise or vibrations from the fan to the rooms below is eliminated. Further precaution was taken by using outboard bearings on the fans, these, in addition being placed on a two-inch cork mat. The fan discharge is connected to a galvanized iron ventilator on the roof above by means of a heavy oiled canvas. Rotary ventilators are used, as this type of ventilator allows fans to discharge to the atmosphere with the least possible back pressure. Furthermore, a ventilator of this type furnishes a certain amount of ventilation in the event that the fans are not in operation.

Four main galvanized iron vent ducts extend up through the building from ground floor ceiling to the exhaust fan chamber in the attic, increasing in size as they go up and additional floors are added. Horizontal ducts branch from the main risers at the ceiling of each floor; these branch ducts are concealed by a false ceiling over the corridor extending through the wings of the building with patient's rooms on each side. From these branch ducts smaller ducts are connected to registers located in each room.

In each room two registers are placed, one at the floor and one at the ceiling, opening into the same duct. These



The boilers at St. Joseph's Hospital.

register openings are provided with interchangeable faces, one of the bar design or open type, and the other solid. The solid face is placed on the register at the ceiling in the winter time and the open one at the floor and this procedure is reversed in the summer, thus taking the air from the floor in the winter and from the ceiling in the summer.

In order to save floor space in the rooms and also to save an ugly break in the wall line, the room vent ducts are of a uniform size and are carried in the tile partition. The eight-inch tile is scored before being burned in such a manner as to be easily broken in two and the web removed. The two pieces of tile were placed around the galvanized iron duct as the partition was built making a solid tile wall.

The main kitchen is located in the northwest wing of the building on the ground floor, and with the dining rooms, storage rooms, baking rooms, etc., is provided with a separate exhaust fan.

The vent ducts from these rooms and from the range hood are connected to a tile-lined brick flue extending up on the outside of the building. At the roof a pent house has been built to enclose the kitchen exhaust fan. The inlet of the fan is connected to the flue with a fire damper in it, so arranged that in case of a fire in the flue a fusible link would be melted and the damper would close, allowing flame to go out top of flue and preventing damage to the fan.

The heating and ventilating system was designed by the writer. It has been in operation for about six years and has proved very satisfactory.

CARE OF SURGICAL INSTRUMENTS

By MARGUERITE ROBB, R.N., Supervisor in Charge of Operating Rooms, Peter Bent Brigham Hospital, Boston, Mass.

THE care of surgical instruments is based upon the principle that instruments should be available for use at their maximum efficiency. This entails systematic grouping in cabinets, efficient methods of cleaning and oiling and constant vigilance as to necessary repairs and sharpening. This is particularly important in regard to some of the finer, special instruments as cystoscopes and other electrical apparatus and machinery.

Instruments should be placed on shelves in cabinets in such a way that they may be quickly reached at any time and are always available for use. Arrangements and grouping are important in order that desired instruments if wanted in a hurry can be easily located. Thus, sharp instruments, such as hemostats or forceps, should be kept in groups, as should also, the instruments used in bone operations, gynecological surgery, etc. It is well also to have certain emergency sets such as tracheotomy and transfusion sets, either put away sterile or kept together so that they are ready for immediate sterilization.

During operations care should be taken to see that instruments, especially delicate ones, are used only for the purpose for which they were made. Thus, hemostats are not to be used to clamp towels together; nor are knives to be used as periosteal elevators. Rough usage quickly ruins such instruments and the next time the apparatus is wanted it may be in the repair shop. For the same reasons, care must be taken that instruments are not sent to the laundry with soiled linen.

Clean Immediately After Use

After operations instruments should be immediately cleaned, preferably with some standard cleansing powder, washed with hot water and dried while hot. Sharp and delicate instruments should be cleaned apart from dull, heavy ones and immediately protected, either by the use of cotton wrapped around the blades or by being put away in special cases. Needles should be run through an emery bag. After septic cases all instruments including scalpels, scissors and needles should be boiled five minutes.

It is important that all instruments with joints should be oiled after daily use. For most instruments ordinary liquid petrolatum is very good; for very fine instruments dental oil may be used.

Boiling tends to dull sharp instruments, hence they should be boiled for a shorter period of time or allowed to stand in some solution such as alcohol or carbolic. Boiling knives one minute has proved a very satisfactory method of sterilization. Scissors and needles are sterilized by boiling five minutes. When many large dull instruments are to be sterilized together they should be boiled ten minutes. Instruments with corrugated jaws should be unclamped before being boiled. All instruments may be boiled in plain water; it is not necessary to add soda to the water unless it contains ingredients which are harmful to the metal.

A precaution necessary in some localities in order to have instruments in good condition is to have the water supply which comes to the sterilizer filtered. Then no deposit is left to coat the inside of the sterilizers and cling to the instruments. Although this deposit is sterile it makes the instruments look bad and makes their cleaning very difficult.

A few instruments require special attention. All needles for aspirating or hypodermic use are cleaned by forcing warm soapy water and then clean water through them. They may be dried without discoloration by holding them with forceps over an alcohol flame. An oiled stylet should then be inserted; no needle or trochar ever being put away until this has been done.

Cautery tips are cleaned after use by heating the tips red hot; thus any adherent particles are burned off. After being allowed to cool, they should be wiped off with a piece of soft gauze; they should never be put in water.

Cystoscopes also require special attention. After use they should be allowed to stand in carbolic acid or lysol solution and then cleaned with soap and warm water. For cleaning various parts long cotton swabs and tooth-pick swabs are very handy. Pipe cleaners are excellent for cleaning the small valves. After thorough drying, these should be oiled with dental oil and wrapped up in a towel. They should then be sterilized with formalin vapor in a metal box made for this purpose.

All glass syringes and metal syringes are sterilized by boiling in separate parts. After use they are carefully washed and boiled in septic cases. Plungers of glass syringes are oiled with liquid petrolatum but something like petrolatum ointment is more efficacious in the lubrication of metal plungers. Syringes like Gentile and Record syringes which are made of glass and metal with metal plungers are best sterilized by soaking in alcohol or some such solution. They are very easily broken in boiling. Also the heat expands the metal and sometimes if the plunger is not allowed to cool sufficiently it is inserted with great difficulty and syringes are easily broken in this manner.

Repair Promptly

Repair work should never be postponed. Loose jointed clamps and all other jointed instruments in which the joint is not working absolutely satisfactorily should be discarded from the instrument cabinet and when a sufficient number have been collected should be repaired. Instruments should be renickeled before the process of wear has gone too far. Any instrument supposed to be sharp is of no value unless it really is sharp. Therefore, knives, scissors and other sharp instruments need practically daily attention. The same may be said of razors which constitute one of the most important implements of the surgeon.

When a hospital of 250 beds or over has a machine

shop which is equipped with lathe, forge, blowers, etc., it is a saving of money and time to have all ordinary repairs and sharpening done there. Blades for scalpels may also be made in such a shop and soldered on to handles; when these blades are worn out they are easily replaced with new ones. A skilled man is necessary to carry on this work and it is doubtful if there would be enough work to keep him busy in a hospital of less than 250 beds.

Hospitals should aim at buying the simplest instruments which will be satisfactory for use. Manufacturers of surgical instruments should try to make them with as few corners and joints as possible. Solid steel handles are far superior to ivory and wooden ones which cannot be boiled.

Careful buying, the use of time and money saving devices and eternal vigilance in their care are three important factors in the upkeep of surgical instruments.

THE CARE OF RUBBER GOODS

By KATE MADDEN, R.N., Directress of Nurses, The Brooklyn Hospital, Brooklyn, N. Y.

Rubber articles are destroyed so easily and deteriorate so quickly that too large a stock on hand (especially gloves) is to be avoided. They should be kept in a dry, cool place as exposure to heat and moisture tends to destroy the rubber, shortening its life. They should be protected from the action of fats and acids by careful washing to remove materials used for lubrication, etc. Rubber sheets and pillow cases when not in use should be hung on a bar; never folded. We have such bars in every ward; they are eight feet long to allow the sheets to hang out straight.

The marking of rubber articles is important; all new articles, except gloves and rubber dam, are marked for the ward they are issued to in the storeroom. Sheets and pillow cases are stamped on the border. Hot water bottles, ice caps and air rings have metal tags which are not easily removed. This careful marking enables us to place the responsibility for carelessness or misuse of the article and tends to prevent that bane of hospital existence, borrowing.

Rubber sheets are washed with 2 per cent carbolic, scrubbed with soap and water, rinsed and dried, hung on bar and covered with a cotton sheet.

Air rings are washed with 2 per cent carbolic, scrubbed with soap and water, dried, partly inflated and hung on a bar which can be lifted at end.

Hot water bottles are washed, drained out well, dried, inflated, top inserted and hung up.

Ice caps are drained, washed, dried inside and out, a piece of gauze placed inside to prevent cutting of the rubber, inflated, top screwed in and hung up.

Rubber dam is soaked in 2 per cent carbolic for half an hour, scrubbed with soap and warm water, rinsed, dried, powdered and rolled.

Rectal tubes, catheters, tubing, drains, etc. are wiped off with tissue paper, washed with cold water to remove all adherent matter, washed with warm water and soap to remove lubricant, rinsed, placed in boiling water for two minutes, immersed in cold water, dried, hung up to drain, put away in large sheet glass jars, in which they are carefully coiled.

Rubber gloves.—Our custom is to give new gloves, except in special cases, only to the operating rooms, the maternity delivery rooms and the laboratories; mended gloves are furnished the wards. The routine care of gloves, mended and new, all over the hospital is as follows:

"New gloves are boiled in normal saline for five minutes, they are thoroughly dried on both sides, powdered, put in glove cases and sterilized in an autoclave under fifteen pounds pressure for ten minutes. A puff of cotton with extra powder is sterilized with each pair of gloves. After use gloves are washed with cold water, immersed in lysol 1 per cent for twenty minutes, tested for leaks, dried and mended if necessary, powdered thoroughly on both sides and put in glove cases and sterilized. As much of the wear of gloves is due to tearing when they are put on, the wrists are turned back and when the hand is inserted into the glove, the other hand is slipped under this turn-back wrist and the glove is gently pushed on over the hand. This serves two purposes: it prevents tearing of the glove and keeps the fingers of the other hand clear.

Our glove cases are made of unbleached cotton, fairly heavy, and are cut thirty-six inches long by eighteen inches wide. This case is lined with one layer of sheet wadding, turned in and finished all around and stitched across from each corner to hold the wadding. They are folded to form a double pocket not quite meeting in the center; when finished they are sixteen inches long and nine inches across the pockets. We find they protect the gloves, stand washing and sterilizing very well and wear for a long time.

Hard rubber articles are kept in bichloride 1-20θ, and are boiled only in special cases.

THE DISPOSAL OF KITCHEN WASTE

By HELEN P. TAYLOR, Assistant Dietitian, Rhode Island Hospital, Providence, R. I.

The Rhode Island Hospital has a system of checking the food waste that is simple yet quite satisfactory. Large galvanized iron cans with covers are used for garbage receptacles. Because the waste food is sold and fed to swine, it is necessary to keep these cans free from water, paper, peanut shells, etc. Since there is a greater tendency toward the waste of bread than any other food, it is against the rules to throw bread into the garbage pails.

When the plates are scraped, all pieces of bread are removed and placed in a separate container, which is collected once a day and taken to the diet kitchen where it is weighed and the contents dumped into a large garbage can. A record of the weight is sent daily to the graduate head nurses in charge of the wards. At times printed lists of the per capita waste of the various wards and dining rooms are posted on the bulletin boards. Each day it is the duty of a senior nurse to send a signed slip to the training school office, stating that she has examined the garbage and found it in satisfactory condition. Thus she is held responsible for the contents of the can on her particular ward.

The garbage cans are removed twice daily from the kitchens and serving rooms to a small brick building away from the wards and used only for the storage of garbage and the cleaning of garbage cans. Here it is tipped slowly out into large barrels, under the eyes of one of the dietitians. Foreign matter and food waste that in her judgment are excessive are reported to the head dietitian. Any complaint concerning ward cans is turned over to the superintendent of nurses, who holds the nurses who signed the garbage reports responsible. Complaints against the cans from the kitchens and serving rooms are traced through the heads of these departments and an effort is made to see that carelessness and mistakes are not repeated. The employes, knowing

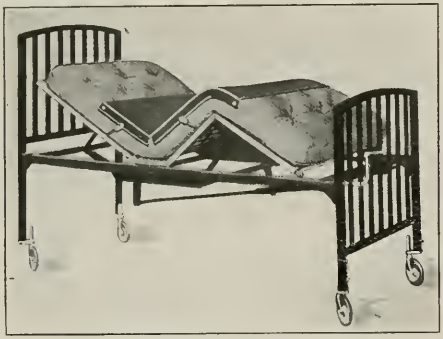
that the waste is thoroughly examined, are more careful.

This system of inspection serves mainly as a check on the quantity of food wasted. Its control begins from the moment the food is purchased until it is served to the individual. Much depends upon good storage facilities and upon grading raw products. Thorough oversight in the preparation of raw foods and careful cooking save much food material. Immediate and wise use of leftovers keeps the kitchen garbage cans low, while care in serving, with attention paid to quantity and neatness, saves food in the serving rooms and ward kitchens. For proper control of food waste there must be an unceasing viligance and a thorough cooperation from all those who come in contact with the food.

A RUBBER BED SHEET THAT DOES NOT WRINKLE

A constant problem of the nurse is the prevention of wrinkles in the rubber bed sheets when used on adjustable beds in the Fowler and similar positions. This wrinkling, as is well known, causes great discomfort to the patient.

One of the leading manufacturers has recently brought



out a simple device which is claimed absolutely to prevent the wrinkling of the rubber sheet. On either side of a standard rubber sheet are inserted two pieces of light wood, the ends of these pieces nearly meeting, and the intervening gap forming a hinge to conform to the fold in the mattress. The wood stay rods hold the rubber sheet smooth and without wrinkling, regardless of the change of position that may be made in the mattress and spring. Further assurance against wrinkling is gained by the use of special rubber sheet straps, as shown in the illustration.

A LABORATORY SIZE OF THE MERCURY ARC

The unique value of the mercury arc as a source of monochromatic light has been recognized for many years. Its use, however, has been limited to commercial purposes and to physical laboratories where the large size unit could be used.

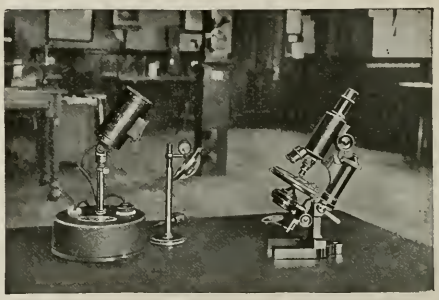
There has now been introduced a special laboratory size of the quartz mercury arc lamp, combining all the advantages of the larger industrial unit with special provisions for safe and convenient use in the laboratory.

This unit has an effective light source area of ¼"x1¾", which is ample for the illumination of such slits or filters as are ordinarily used. It is enclosed in a metal casing to protect the observer from stray light and is provided with a removable mica filter to absorb the far ultra-violet when it is not needed. It emits so little radiant heat that it may be used near to accessory optical apparatus.

This unit has the same high intrinsic brilliancy as the larger quartz lamps and provides the same characteristic radiation.

An important feature of this device is the fact that it will operate successfully on 110 volt, either alternating or direct current, the arc proper being connected to the auxiliary electrical equipment in the base by a separable connector and standard laboratory fixture, permitting wide adjustments and adaptability.

The particular value to the hospital of this new lab-



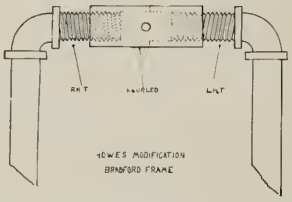
oratory arc lies in microscopy and photomicrography.

There are unique advantages in the mercury arc for microscope illumination. High intensity in monochromatic green results in maximum sensibility, minimum fatigue and high acuity and resolving power for visual work. For general illumination of microscopic objects the laboratory arc may be used with advantage with the standard green filters used for microscopic work.

High intensity in the extreme ultra-violet results in an effective source for ultra-violet photomicrography through a quartz fluorspar optical system. Quartz-fluorspar microscope lenses are now available and the new laboratory arc is adaptable to this type of work.

A MARKED IMPROVEMENT IN A BRADFORD FRAME

Those who have occasion to use Bradford frames are familiar with the difficulties experienced in adjusting the canvas upon the frame. The eyelets pull out, the cord loosens, the canvas sags so that different degrees of ten-



sion exist at different points along the length and breadth of the frame. A frame that is in perfect adjustment one day may be far from satisfactory a few days hence.

These difficulties have been obviated by an improvement devised by Dr. Willard B. Howes, superintendent of the Detroit Tuberculosis Sanatorium. In the Howes modifica-

tion, the frame consists of two U-shaped pieces of one-inch tubing, which are joined at the narrow ends of the frame. The ends of the tubing at this joint are made with right and left threads and are connected by coupling similar to an ordinary union. This coupling is made with a knurled surface in the center which also contains holes for the insertion of a metal pin or rod to facilitate the turning of the coupling for extension purposes.

The canvas is cut to give a double thickness, stitched in the form of a cylinder and slipped over the frame like a pillow case over a pillow. Then, by turning the special couplings at either end the side rails are pushed out, giving a drum-like tightness to the canvas.

By thus utilizing a double thickness of heavy canvas the hospital is assured of long wear, while a uniform tension can be maintained at all times. Furthermore this tension can be adjusted without removing the patient from the frame.

NEW COMBINATION BED CHAIR PLEASES CONVALESCENTS

The Loomis Sanatorium, Liberty, N. Y., has recently adopted a new type of adjustable bed chair which is proving quite successful. This consists of the ordinary type of hospital bed to which has been added an extra high canvas back rest, adjustable to various positions. Through

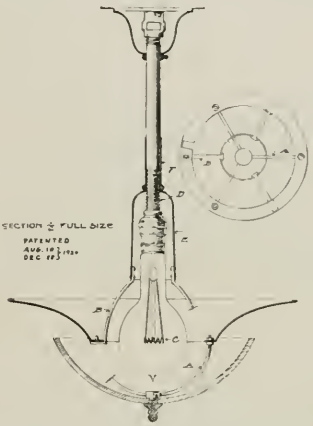
the use of this combination bed chair the sanatorium is able to economize on floor space, as it removes the necessity of an adjustable cure chair for each patient in addition to the bed.

The back rest in its vertical position, when the bed is to be used for sleeping, protects the head of the sleeper from draught, as the canvas back comes down close enough to the mattress. In the daytime when the bed has been made up a khaki colored canvas cover fits over it, and when the back rest has been pushed forward and down to an inclined position, the bed resembles a reclining chair.

The method of adjustment on this back rest is quite unique, providing a wide range of positions and greater comfort for the patient than is possible with the ordinary low back rest used on hospital beds. The use of this bed chair is said to be particularly desirable in tuberculosis institutions. When another lot of these chair-beds is produced, it is planned to make them with a movable foot rest extending the length of the bed when the back is inclined.

A SPECIAL LIGHTING FIXTURE FOR THE HOSPITAL

One of the notable features of the new private room pavilion of the Mount Sinai Hospital, New York, are the lighting fixtures. These were specially designed so as to give ample general illumination of the room without any



direct light being reflected in the eyes of the patient. As can be seen from the illustrations, this unit has a very low interior brilliancy without being dark, insuring great eye comfort to the patient. Nearly 80 per cent of the light is thrown on the ceiling, giving a general illumina-

tion that approximates daylight, so that surgeons or nurses are not hindered by lack of light or the presence of shadows.

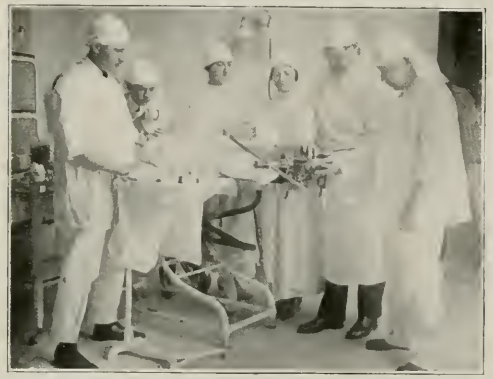
The reflector on this unit is made of porcelain enamel, easily cleaned.

THE LORENZ CLUB FOOT MACHINE

One of the results of the recent visit to the United States of Dr. Adolf Lorenz, Austrian orthopedic surgeon, was the introduction in this country of a new device for the manipulation and straightening of various

forms of club feet, particularly talipes varus and valgus.

The use of this device has proved very successful, greatly simplifying the work of the surgeon and permitting a more exact and perfect manipulation of the foot. The upper illustration shows this machine in use in the Kings County Hospital, Brooklyn, N. Y., preliminary to the application of a plaster-of-paris cast. The second illustration shows a close-up of the machine as applied to the foot.



SUGGESTS ECONOMIES IN USE OF STEAM BOILER

A recent number of *The Hospital*, an English publication, made some practical suggestions on economy in the use of steam boilers. It pointed out that one of the points that has been overlooked in the past, has been the question of obtaining the right temperatures at different parts of the steam system. The economy of any heat system depends upon the range of temperature that is usefully employed. The boiler may be considered as two heat engines, first, the furnace, in which the coal is burned, with its accessories the flues, through which flow the hot gases formed by the combustion of the coal; and second, the water and steam portions. The range of temperature that is usefully employed marks the limit of the efficiency of the system. The higher the temperature at which the heat engine starts, and the lower the temperature to which it works, the greater is the economy. *The Hospital* goes on to say: "When coal is burnt in the boiler furnace the gases that are produced by the combustion are raised to a high temperature, and this temperature marks one of the limits of economy. Before economy was studied a temperature of 2,000° F. was usually the highest contained at the furnace itself; and, on the other hand; the hot gases were delivered at the base of the chimney often at a temperature of 1,000° F. This means that only 1,000° F. of 50 per cent of the total range of temperature, was usefully employed, and therefore, the highest efficiency theoretically obtainable in the boiler furnace was 50 per cent. Against this there were always other losses, such as the leakage of air into the boiler flues, the partial stoppage of the draught by clinker on the grate bars; and the efficiency of the boiler as a whole was necessarily less than 50 per cent, because the efficiency of the steam and water side had to be equated with that of the furnace portion. Hence the combined efficiency might easily be in the neighborhood of 30-35 per cent. Even now, attention has been given to the subject, measurements that have been taken upon boilers in use show that efficiencies of only 30-35 per cent are common, while it should be perfectly practicable to obtain an efficiency of at least 75 per cent.

"In the modern boiler the furnace temperature has been raised to 3,000° F., while the hot gases are delivered at the base of the chimney at 300° F., and in some cases at 200° F.; in one type of boiler a temperature of 3,500° F. has been obtained in the boiler furnace. Taking the case of the furnace having a temperature of 3,000° F., and the temperature of the gases delivered to the chimney at 300° F., the possible furnace efficiency is raised to 81 per cent. This means, of course, decreased coal consumption, decreased capital cost and decreased labor.

The question then arises concerning how the high temperature mentioned shall always be present in the boiler furnace, and the low temperature at the base of the chimney; and the answer is, by the constant use of measuring instruments, of thermometers specially designed for the purpose."

It is the custom of large manufacturing plants, railroads, and other large industries, to have an inspection of all machinery, locomotives and other mechanical devices made yearly, in order that such equipment may be kept in proper functioning condition. Now, why is this done? The answer is, in order that such equipment may be in proper condition at all times to do its maximum duty. Business interests have also learned that it is far cheaper to prevent accidents than to pay for the results of accidents. It is also a fact that the larger business enterprises have extended this policy to their employees, for practically every business of any great size maintains its own medical establishment whose sole duty it is to see that none but the physically fit are given employment. The function of this medical branch in numerous instances extends to the homes of employees. Why these precautions? Solely because sickness makes serious inroads into the efficiency of any establishment. If such a policy is good business, why not try it?

"Persuasion is little else than the art of introducing into a man's mind unwelcome ideas so neatly as not to arouse the will to expel them."—Ross.

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

THE OCCUPATIONAL THERAPY SITUATION IN MASSACHUSETTS

BY JOHN D. ADAMS, M.D., VICE PRESIDENT, MASSACHUSETTS SOCIETY FOR OCCUPATIONAL THERAPY, BOSTON.

THE term occupational therapy does not convey to the average lay mind a true conception of just what field the work covers. Therefore, it has been necessary in introducing this work into a community to give a much more comprehensive educational campaign than the average new idea would require. In Massachusetts we find one of the strongest arguments to substantiate its existence is the fact that its severest critics have become our warmest supporters.

The organization of the work is centered around the school and the state society, with the allied bureau. The school which has been in existence since the war emergency was incorporated some six or eight months ago and under the admirable supervision of Miss Ruth Wigglesworth and Miss Marjorie Greene it is graduating a class of twenty-two aides in October.

Our school occupies the building formerly used by the Sloyd Training School. During the past month through the efforts of the board of managers the building has been purchased from the Shaw heirs and it is now the property of the Boston School of Occupational Therapy. We consider this somewhat of a triumph as it enables us to broaden the scope of our work to the extent of bringing under one roof facilities for teaching all of the arts and crafts necessary in this work.

Our medical course as outlined in Baltimore last year has been completed and a very comprehensive course of lectures is being given to our present class.

We are at present receiving a great many applications probably more than we can meet, for our class for next year.

The work of our state organization has gone on a trifle more slowly, and at present numbers about 150 members.

The publicity work is under the supervision of a publicity committee, which has arranged meetings in many outlying towns, and speakers with a set of lantern slides are attempting to interest these communities in the work.

Our plan of organization is to form a separate committee in each community, all members of which shall become members of the state organization and shall so plan their work as to cooperate with the activities of the state society under the direction of Miss Harriet Robeson, our director.

We have set as a goal 2500 members for the state organization. This is absolutely necessary to finance the plans already laid out, as our budget for the year is approximately $6,000.

Membership in the state organization includes membership and privileges of the bureau, which has been in existence for some time. The bureau is situated at the corner of Berkeley and Boylston streets and is a clearing house and selling place for goods made at the various institutions throughout the state. The bureau charges fifteen per cent profit for selling the articles.

The work of introducing this movement into small towns and cities is arduous, but on the whole we find people receptive to the work and the response has been increasingly encouraging.

OCCUPATIONAL THERAPY IN MICHIGAN

By CAMILLA B. BALL, Detroit Chapter of American Red Cross, Detroit, Mich.

The Detroit Chapter of the American Red Cross has sponsored occupational therapy in Michigan since 1917. During these years, at the suggestion of the surgeon general, a Red Cross Training School has been conducted at Newberry House. More than 100 women have been graduated from this school and some of these aides were among the first to respond to a call for service among the returning invalided soldiers. Many of these girls are still in the work in both government and civilian institutions.

In June, 1921 the last class of occupational therapy was graduated by the Red Cross Training School at Newberry House. Negotiations were undertaken with the Detroit board of education to take over the Red Cross school. These negotiations were successfully completed in January, 1922. The board of education can offer a course in occupational therapy; students will receive their craft training at Cass Technical High School, their lectures at Medical College and psychology and teaching methods at Teachers' College. It is possible for a student entering the eighth grade to take occupational therapy work through the four high school years. Out of a minimum 160 credits required for college entrance requirements, it is possible to take sixty-five credits in design and occupational therapy crafts. This establishes occupational therapy in Michigan upon an accredited basis in college. At the conclusion of the work in high school, six months' work is arranged in lectures and

practice training. In connection with this regular high school work any special student may enter and take the work in occupational therapy. Credit will be given for any previous work that has been done in this line. So far as we know, no other board of education in the country has incorporated occupational therapy in the regular high school program.

The civilian hospital is quite in the eye of the public today and details of that type work are of interest to readers of THE MODERN HOSPITAL.

The Receiving Hospital, Detroit's big municipal institution, has made a signal success in the last year in occupational therapy. In March, 1921, the Red Cross, through the occupational therapy department at Newberry House, made a demonstration of occupational therapy that cost in terms of dollars and cents, $67. A splendid aide, Mrs. Rowena Gregory, made the demonstration and as a result of her work, the city took over the department and asked Mrs. Gregory to "carry on" in this humane and therapeutic work in the hospital. After a year, the department in review has been a wonderful success. A sales department is growing and several big orders for baskets from florists have been filled.

Miss Hazel Baxter, a Red Cross graduate from Newberry House in January, 1921, volunteered for two months' service at the Homeopathic Hospital in Ann Arbor. Her demonstration was interesting enough for Mrs. Mallory of the hospital social service department to undertake the financing of the work for the year. The department is still flourishing and will do much to carry the gospel of occupational therapy farther in Ann Arbor. The Homeopathic and University hospitals are to be amalgamated and we are hoping to see a larger department for occupational therapy grow at Ann Arbor in the future. Miss Baxter is still dispensing therapy and is combining social service with the occupational therapy.

A department the Michigan Association is rightly proud of is the one instituted at Howell State Sanatorium by Miss Christine Newman. Miss Newman, a Red Cross graduate from Newberry House, has a wonderful combination consisting of executive ability, knowledge of a buying public, a sense of artistic values and tremendous enthusiasm. Honors for the success of this work are to be divided equally between Miss Newman, occupational therapy director and Dr. Eugene B. Pierce, superintendent of the hospital. It is due to his interest and support that funds were obtained for the work in the occupational therapy department. Miss Newman has obtained large orders from stores in Detroit for various articles. As a result of this standardization, she has little unsaleable merchandise in the hospital. For the coming Christmas trade she is specializing in bassinets, work baskets, bedside tables and muffin racks. She also has a special small basket with a cover that is selling by the hundreds. She says her idea of this basket cover was obtained at the national conference in Baltimore last October. This one idea alone, she declares, compensated her for the trip there and back.

Eloise is the Wayne County Home and Insane Asylum. In 1920 occupational therapy had a short lived career there. Many factors contributed to the failure. Mr. Bennett, the new superintendent of Eloise, has recently reinstated occupational therapy upon an entirely new basis. Mrs. Martha Murphy from Newberry House is at the helm and indications presage an ideal environment for successful occupational therapy. The work is being instituted in the insane asylum and among the tuberculosis patients.

Occupational therapy is entering many institutions. Last January the House of Correction, a penal institution, employed a Newberry House graduate therapist, Mrs. Rhones, to do occupational work with the woman prisoners. Chair caning is especially featured and Mrs. Rhones is having much success with a rather difficult class of women. Newberry House is lending some looms to help develop a weaving class. We hope by 1923 to see a large piece of work under way.

In January the Detention House for the juvenile court opened a department for occupational therapy. Mrs. Potvin, a Red Cross graduate formerly of Newberry House and later of the Michigan Mutual Hospital, was employed by the city to do the work among the boys and girls of the detention home. Judging from her past successful work, this new department will flourish and grow. Newberry House has given some emergency Red Cross equipment for the furthering of this work. Among other things were a large manual training table for eight workers, jewelry equipment for one, a Devereux Mansion loom, a Dandy weaver loom, drawing table and anvil block. The Red Cross and the Michigan Association are delighted over this field among the young people.

The Michigan School for Crippled Children, located at Farmington just out of Detroit, is an interesting hospital for crippled children and is ideally situated for this type of work. Occupational therapy was introduced there in 1919 but the work failed to grow. This year at the request of Mr. Wheeler, occupational therapy was reinstated under Miss Christine Brown, a graduate of the Red Cross Training School, and one of the most successful aides in Michigan. Miss Brown is working out some interesting problems there, and finds the general atmosphere of the hospital is cordial.

There are various other departments in operation in the city of Detroit and there are some interesting activities in formation.

THE ROLL CALL

The strength of the state societies and associations is growing, as evidenced by the membership. Societies have responded to the roll call with the number of their members as follows:

ILLINOIS
Active 54
Associate 2

MANITOBA
Active 30
Associate 12
Honorary 2

MARYLAND
Active 75

MASSACHUSETTS
Active 149
Sustaining 27
Life 12

MICHIGAN
Active 30
Associate 10

MISSOURI
Active 28
Board 11
Sustaining 125

NEW YORK
Active 160
Supporting 47

ONTARIO
Active 95

PENNSYLVANIA
An association of Occupational Therapy is being organized. At present 20 aides in active service have joined, and it is expected that the association will grow rapidly.

WASHINGTON, D. C.
Active 30
Associate 2

WISCONSIN
Active 50
Associate 6
Sustaining 4
Honorary 5

CONVENTION PROGRAM ANNOUNCED

A tentative program of the annual meeting of the American Occupational Therapy Association to be held in Atlantic City during three days of the session of the American Hospital Association, September 25-28 is announced in the Department of Meetings, Conferences and Conventions, page 176.

NEWS ITEMS

Illinois

On April 29, 1922, the Illinois Society of Occupational Therapists held an open meeting at the Auditorium Hotel, Chicago. Luncheon was served to over one hundred fifty guests, after which Dr. Harry Mock addressed the meeting on "Occupational Therapy as a Part in Complete Rehabilitation." He offered great encouragement as to the future part of occupational work in reconstructive surgery, and spoke enthusiastically of the need for Convalescent Centers, places removed from the hospital where rehabilitation will continue with occupational therapy as one important function of such treatment. Dr. Mock's talk was illustrated with lantern slides and contained interesting pictures and descriptions of some exceptionally satisfactory results in functional restoration due in large part to occupational therapy.

Mrs. Eleanor Clarke Slagle spoke on "Occupational Therapy, the Present Demand and Future Needs." She gave a brief outline of the organization of occupational departments in Chicago hospitals, and suggested that "the work cure" was the result of the dreams and visions of the middle west. Mrs. Slagle put before the meeting a problem for solution, namely: How to keep records of therapeutic value for the information of the scientific man?

Others of prominence in hospital and occupational work, Mrs. Zimmer of Cook County Hospital, Mrs. Carl Henry Davis of Milwaukee, and Miss Kidder of St. Louis were then asked to say a few words.

The meeting adjourned after Mrs. Slagle had given the tentative program of the meeting of the American Association of Occupational Therapy to be held in Atlantic City in conjunction with the American Hospital Association in September.

Manitoba

The following changes have been made in the staffs of different hospitals:

Upon the opening of an occupational department in the new School for the Feeble-Minded at Portage la Prairie, Mrs. Elizabeth Patten was transferred on April 1 from Selkirk to take charge.

Miss M. Williams, who has been in the occupational department at Selkirk Mental Hospital, is leaving to take up work at Bloomingdale Hospital, New York. Her place is being taken by Miss M. Huston.

Miss H. Morgan resigned from the Mental Hospital at Brandon on April 1, and Miss Jean Billington has been appointed to assist Miss M. Pierce, who will be in charge.

The regular meeting of the society in April was an interesting one. There were visiting aides from several of the other provinces of Canada. After the business was transacted, the president called upon various active members of the society and the visiting aides to tell some incidents in connection with their work that made them feel it had been beneficial. As many kinds of hospitals and widely separated localities were represented, the time was too short for all that might have been said. Associate members seemed to take as keen an interest as the active in the various phases of the work. The committee serving tea thought at one time they would have no chance to take their "innings." Some were even guilty of talking shop during the tea hour.

"The Private Secretary" is being presented on May 25 in Dominion Theater for the benefit of the Society.

Maryland

The Union Memorial Hospital and University of Maryland Hospital are initiating volunteer occupational therapy workers. For professional occupational therapy workers give instructions in studios or private homes.

Massachusetts

The Massachusetts Association is continuing its plan of publicity meetings as a means of familiarizing the general public with the meaning and purpose of occupational therapy.

April 21:

Dr. John D. Adams, vice president, spoke at a meeting held in Memorial Theater, Plymouth; about 150 persons were present.

April 16:

Dr. Adams spoke at the Boston Dispensary to an interested audience of doctors and social service workers.

April 18:

Miss Harriet A. Robeson, director, spoke at the monthly luncheon of the Professional Women's Club at the Copley Plaza Hotel, with about 350 of Boston's active women present.

April 20:

Dr. Herbert J. Hall and Dr. Adams spoke in Worcester at a meeting held under the auspices of Memorial Hospital. The audience included doctors, nurses, social service workers and many interested residents of Worcester.

May 3:

Miss Robeson addressed a meeting of the Unitarian Women's Social Service Council. It was an exceedingly keen and interested audience, and because of this meeting the association has been asked to send speakers to three meetings in Boston suburbs.

May 10:

Miss Robeson spoke at the Bancroft School in Worcester to a group of graduating students, with the view of interesting the girls in occupational Therapy as a future profession.

The Association has collected about forty occupational therapy slides which have been shown at most of the meetings and have been a great help in explaining to the public the application of occupational therapy as treatment in convalescence.

The increasing membership in the association, requests for speakers and information, and in the sales of the finished product of our bureau, seem to show that this method of publicity is bearing worthwhile fruit.

Michigan

A meeting of the Michigan Association of Occupational Therapy was held at Newberry House at the Red Cross office on Tuesday May 9.

The Michigan Association is sending out a form letter to elicit the interest of prospective members with the purpose of increasing both active and associate memberships. It is watching with interest the growth of an occupational therapy department at the Psychopathic Hospital in Ann Arbor. The work is under the direction of Dr. Barrett, director of hospital, and Miss Malcomson, director of medical social service.

Members of the Michigan Association are compiling a book of patterns and designs for professional use. The work is being done on linen to secure durability. The book is available at the Red Cross office at Newberry House and is the property of the association.

Missouri

All of the state elemosynary hospitals have been provided with occupational therapy, including Mt. Vernon State Tuberculosis Sanatorium.

The St. Louis School of Occupational Therapy completed its craft work, May 22. It held an exhibit of students' work at the City Hospital during the American Medical Association convention.

New York

Nothing of definite nature to report other than that contained in our summary of March 1. The workshop is progressing nicely and we have already sent two men into industrial work.

Ontario

The chief activities of the Society are now directed towards the establishment of a community workshop in Toronto.

Regular monthly meetings are held, the May meeting taking the form of a birthday party for the members and their friends. It was so successful that it is prepared to make it an annual affair.

Pennsylvania

The graduating exercises of the Philadelphia School of Occupational Therapy were held June 8. The Hon. Roland S. Morris was one of the speakers. A class of thirty was graduated at that time.

The Alumnae Association of the Philadelphia School of Occupational Therapy held its annual meeting on June 9, 1922.

The second meeting of the Association of Occupational Therapy Aides met at the Philadelphia School of Occupational Therapy on May 6 for the purpose of electing officers and of formulating plans for the future. Twenty aides in active service have joined and it is expected that this association will grow rapidly.

Washington

On May 7 took place one of the most interesting meetings of this organization for the year. It was held at Walter Reed Hospital and was largely attended. The program was opened by Major Sherwood, director of occupational therapy at Walter Reed Hospital, and he gave a history of the work there. There were two papers by prominent men from out of town—Captain Pratt of Kankakee, Ill., and Dr. Robert Farnstall Taylor of Baltimore. The other able address was given by Dr. William A. White of St. Elizabeth's, in which he brought out many practical points in the application of occupational therapy to psychiatric patients. After the program the audience was invited to a social hour in the work rooms, where a special exhibit of the craft was shown and refreshments served.

Wisconsin

Miss Ruth Wilson has left Milwaukee to become director of occupational therapy at Green Gables Sanitarium, Lincoln, Nebr. Miss Margaret Baylan is the new director at the Milwaukee County Hospital for Mental Diseases. Miss Annette Heinrich has returned from the East to become director of occupational therapy at Milwaukee Sanitarium.

The fifth number of the *Wisconsin Journal of Occupational Therapy* has appeared and 1,500 copies are in circulation.

Shut in work for patients visited by Visiting Nurse's Association has been successfully started under the direction of the Curative Workshop.

Miss Hilda B. Goodman, director of the Curative Workshop at Columbia Hospital, has leave of absence to spend the summer in study and travel on the Pacific Coast and Canada.

Miss Irene Grant, director of O. T. at Muirdale Sanatorium, will spend the summer in Europe.

Mrs. Carl Davis attended the executive board meetings of the American Association of Occupational Therapy in New York in the winter and visited the Missouri Association during the meeting of the American Medical Association.

The Wisconsin Association had the pleasure of entertaining Mrs. Eleanor Clark Slagle on June 4 during her brief visit to Milwaukee.

POTATOES HELP TO BUILD HOSPITAL

The lowly spud is Pennsylvania's strongest asset when it comes to building hospitals, say alumni of Pennsylvania State College. Pennsylvania potatoes have entered a new health field and are providing funds for a $200,000 hospital building to be erected at the state school.

At the annual alumni reunion held at Penn State at Commencement time, the potato took the center of the stage. First arrived by special messenger a one-pound spud which was worth fifteen times its weight in gold. Within it was a subscription blank for $5,000, the gift to the proposed hospital of the Somerset County Potato Growers Association.

The next day came a potato crate from members of the Cambria County Potato Growers' Cooperative Association which was filled to overflowing with subscription blanks totaling $5,000 for the hospital.

Potato growers all over the state are rapidly joining the movement, it is said, as their share in Penn State's campaign for $200,000 for an emergency fund for health and welfare buildings.

AL RINGLING'S HOME BECOMES HOSPITAL

Mrs. Della Ringling, widow of the famous showman, Al T. Ringling, has recently given her palatial residence in Baraboo, Wis. to the Sisters of St. Mary to be used as a hospital.

The Ringling mansion is said to be well adapted to hospital purposes with a minimum of alteration. The sunlit ballroom on the upper floors will make an ideal operating suite, according to several surgeons who have inspected the place, and the great pipe organ room and drawing rooms will serve as wards. These with the various bedrooms will provide accommodations for seventy-five patients.

Mrs. Ringling recently underwent an operation at St. Mary's Hospital in Rochester and it is said that her gift is largely an appreciation for the work of the Sisters of this institution and in response to the recommendations of Drs. Mayo.

The gift of the mansion was made with a single requirement: that it be perpetually maintained as a hospital.

GOAT GLAND HOSPITAL OPENS

A goat gland hospital has been established at Ensenada in Lower California, according to recent announcements in the press. The institution was opened on June 15 with a corps of surgeons, headed by Dr. Benson of Calexico in charge. The doctors have leased an old hotel in Ensenada and have converted it into a hospital. Hundreds of goats are to be shipped from San Diego to furnish glands for transplantation.

It is not how long but how well we live.—Delille.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

THE APPOINTMENT SYSTEM IN THE NEW HAVEN DISPENSARY*

BY E. A. PARK, M.D., PROFESSOR OF PEDIATRICS, YALE MEDICAL SCHOOL, NEW HAVEN, CONN.

WITH the establishment of a university (full time) section of pediatrics in the New Haven Dispensary at the beginning of the present university year, the appointment system has been instituted in the pediatric clinic of the dispensary. The advantages of this system, elaborated below, are so obvious that other clinics have decided to adopt it as soon as facilities can be made available. This, it is hoped, will be possible for all clinics when the dispensary is located in the center of the hospital group, according to plan.

System Inaugurated for French Refuges

The first dispensary organized on the basis of appointments for patients was the one conducted by the American Red Cross in Le Havre, France, for the benefit of the children of the Belgian refugees and later for the children of the French refugees and civil population. The plan worked with so much success at Le Havre that it seemed wise to inaugurate it in the organization of the pediatric section of the Yale Medical School.

The pediatric division of the New Haven Dispensary occupies five rooms on the ground floor, four of which are examining rooms and in one the temperatures and the weights of the patients are determined. Another room in the back of the building, divided into three cubicles, is used for the isolation of children with contagious diseases. On the floor above is a room which serves as a laboratory and treatment room. In the main waiting room, benches have been placed for the accommodation of patients and desks have been provided at which doctors or students can record histories. The clerk who receives patients has a desk on the pediatric side of the general waiting room. She makes appointments for new patients as well as for those returning for subsequent visits.

The Staff of the Pediatric Division

The staff at present consists of a dispensary head, ranking as instructor in the university who has no other duties than the management of the children's division of the out-patient department, a first assistant, the four interns of the pediatric service of the hospital and three practicing physicians. These three physicians together serve in the dispensary a total of not more than twenty hours per week. In addition to the staff enumerated there are ten students who obtain a part of their training in pediatrics by work in the dispensary, the dispensary clerk, already alluded to, and a nurse. Patients of special interest or importance in the dispensary are seen by the professors of pediatrics at specified times.

The pediatric division of the dispensary is open for the admission of patients from 9 a. m. to 12 noon and from 2 p. m. to 4:30 p. m. The doors are closed at 5 p. m.

The dispensary clerk functions similarly to the secretary for a group of private physicians. She maintains schedules for each doctor, arranges the appointments, etc.

The "full-time" staff of the dispensary is distributed as follows: 9 a. m.-10 a. m.: physician-in-charge; first assistant; one intern (this intern does the laboratory work for the pediatric service of the hospital and dispensary and has no ward patients); and ten students.

10 a. m.-12 noon: the above staff with addition of two more interns.

2 p. m.-5 p. m.: physician-in-charge; first assistant (not the same one who serves in the morning); an intern who has no morning dispensary duties; and ten students (same group as serve in the morning). Other interns are on first and second calls.

Types of Patient Served

The patients seen on any given day may be divided into two groups, *i.e.*, those who come by appointment (Group A) and those who have no appointments and may be termed "stragglers" (Group B).

The patients in Group A are (1) patients who have recently been to the dispensary and who return at a stated hour on a stated day to see the physicians whom they saw on previous visits. (2) New patients who have received appointments by personal application or by telephone or for whom appointments have been made by social workers, public health nurses, matrons of nurseries, boarding homes, or orphanages, or other workers for health, charitable and social agencies. Three appointments per hour per doctor are made—on the hour, twenty minutes past the hour, and forty minutes past the hour; twenty minutes are alloted to each patient. The appointments are made by the clerk for the physician who simply indicates, in the case of old patients, the day when he wishes to make the next examination. In making appointments the con-

*Condensed by permission from an article by Dr. Park in The Past, Present and Future of the Yale University School of Medicine & Affiliated Institutions.

venience of the mother is respected just as far as possible. By preference the clerk makes appointments early in the morning or afternoon so that the later hours may be free for examination of the so-called "stragglers" who constitute Group B.

The patients in Group B consist of (1) new patients; (2) old patients of recent date who failed to keep previous appointments; and (3) old patients who had been discharged or who had not been coming to the dispensary recently.

The patients who have appointments are seen promptly; otherwise the aim for which the plan was conceived would be defeated; the stragglers are seen when and by whom they may be. These patients are assigned to physicians whose time is free either because of a broken appointment or no appointment just at that period. In as far as possible the intern on laboratory service sees most or all of his appointment cases between 9 a. m. and 11 a. m. so that he may have the 11 a. m. to 12 noon hour free to devote to "stragglers." If the condition of these patients is not acute and there are many applicants, they may be given appointments for the next day; if a laboratory procedure seems indicated, that may be carried out or started so that on the return visit as much data as possible may be assembled.

The "straggler" group will always exist but will doubtless become relatively smaller as the dispensary clientele becomes acquainted with the appointment system.

Although the new system has been in operation only since November 1, 1921, about 90 per cent of the patients are seen by appointment and about 80 per cent of appointments made are kept.

It is obvious from the distribution of the staff that the greatest volume of the work is planned for the morning. This is done so that the afternoon may be used for consultations and for more intensive work on selected cases and groups of cases. A syphilis clinic is conducted during one afternoon and a cardiac clinic and protein sensitization clinic are planned. A health conference for babies and another for older children are conducted at the dispensary by the Visiting Nurse Association of New Haven, the physicians in charge being members of the pediatric staff.

Advantages of System to Patient

The advantages of the appointment system are so obvious as to require little comment. Perhaps the most important result is the saving of the parent's time and, therefore, of his money. The day's wage is of as much importance to the dispensary patient as the day's income to the dispensary doctor; its steady flow is often a matter of vital importance. Yet the dispensary system generally in use, according to which the patients are obliged to assemble before 9 a. m. or 2 p. m., and then to wait often the whole morning or afternoon, implies that the time of the dispensary patient is of so little value that it may almost be disregarded. The truth is that the modern dispensary is conducted, primarily, with a view to the convenience of the dispensary physician, on the principle that it is better for forty patients seated on the benches to lose sixty hours' time, than for the doctors to be subjected to the possibility of losing one-half hour's time. As everyone who has worked in a children's dispensary knows, many a parent who finds himself obliged to sacrifice his day's wage, or, if he works at night, his day's sleep, will not bring his child to the dispensary. Yet such a parent will bring his child to meet the doctor on a day and hour found to be mutually convenient.

If the dispensary patient paid a fee to the dispensary doctor, as the private patient pays a fee to his physician, in other words, if the dispensary doctor had been compelled by his own selfish interest to recognize the convenience and economic necessities of his patients, all dispensaries would have been operated on the appointment plan long ago. There is no reason why a dispensary created for the benefit of the poor should not be conducted from every point of view to their advantage.

Advantages to Physician and Student

From the physician's standpoint this system not only causes no loss of time, but it brings about the very best utilization of time by producing a more even distribution of patients throughout the dispensary day and week. The avalanche of patients which descends on Mondays, on the days following holidays, or the first pleasant day after a period of bad weather, can, to a great extent, be anticipated, or held and distributed. The doctor thus avoids the frequent necessity of abandoning all careful consideration of his cases in an effort to get rid of them as rapidly as possible. Furthermore, the assembling of crowds of children is obviated, exposure to contagious diseases minimized, and the noise and confusion, the two attributes of a children's dispensary, greatly reduced.

From the students' standpoint and from the teacher's standpoint this system also offers advantages. Cases can be grouped by making their appointments fall together or in sequence on given days. Through the more even distribution of patients the students can be kept steadily occupied and their work can be better supervised. The student's interest in the patient can be aroused by making him feel that the case is his. The student expects to be a practitioner of medicine. Under the appointment arrangement he is able to imagine himself to be one.

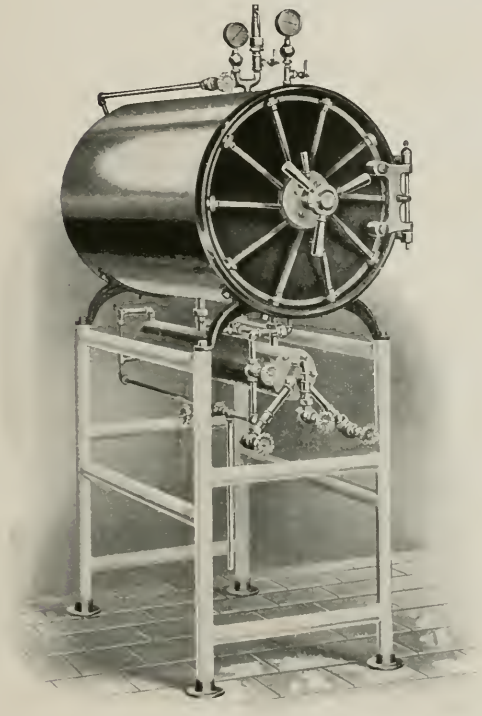
Meet Clinic's Obligation to Community

The great reason for the adoption of the appointment system in dispensaries is, however, not because of advantages which it offers the student or teacher but because it is the only efficient and enlightened way in which a dispensary can be made to discharge its function toward the community. The appointment system makes the dispensary available to all members of the community and brings it to pass that the dispensary reaches a new class of patients, those in moderate circumstances who are unable to afford the services of specialists. It gives not only to the poor but also to the middle classes all the advantages of "group medicine." The extension of the use of the dispensary to people of moderate means is destined to supply a great need, since that class cannot at present afford to consult specialists on the one hand and on the other cannot or are too proud to go to dispensaries as at present conducted.

Furthermore, the establishment of the appointment system in the dispensary makes possible the development of a dispensary consultation practice. The practicing physician, finding that he can have his patient seen by appointment at the dispensary by a specialist, will use the dispensary as a place where valuable opinions and advice can be obtained. As the staff members of the dispensary of the Yale Medical School are essentially "full-time" and do not compete with the local physician, new relations of a friendly nature and mutual benefit are bound to form between the dispensary staff and the practicing physician. The practicing physician obtains

CASTLE

They Ordered a Castle Sterilizer, but in the meantime—



(The Hospital Superintendent and Surgeon were talking—Series II.)

"Good morning, Doctor."

"Morning. How's Miss Smith? Sorry to hear she got burned with that old sterilizer. How did it happen?"

"She thought the steam was all out and unscrewed the door. It flew open with a bang and scalded her. Lucky the door didn't cut loose entirely and hit her."

"I should say so. But isn't there a lock on that door?"

"Why yes, when it is screwed up tight the arms lock it."

"That all?.....And can those arms be unlocked while there is steam pressure?.....Good heavens, we are lucky we haven't blown the whole surgery up."

"The new Castle sterilizer will be here soon."

"Yes, and I am glad of it, because I understand that their door can't blow open. Unscrewing the handle will relieve any steam pressure, but the safety lock that opens the door can't be thrown until steam pressure is down to zero. The Castle man said they never had had an accident in their fifteen years of manufacture, and I can believe him."

Write for Castle Sterilizer Specifications

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valuable advice concerning his patient. The dispensary physician is rewarded by a new and perhaps interesting case.

It is claimed by the opponents of "full-time" medicine that the system does not offer sufficient clinical opportunity to give the staff an adequate clinical education. The appointment system in the dispensary makes most careful work possible. The combination of hospital training and dispensary training, the former in the kind of illness which confines the patient to bed, the latter in the milder forms of disease which the "full-time" physician is commonly supposed not to see, gives the members of the staff unequalled opportunities for a progressive development in clinical medicine. The present pediatric staff regard their dispensary work as equal in value to their hospital work.

The dispensary which operates on an appointment basis is able to cooperate with maximal efficiency with the various charitable institutions. District nurses and social workers from the charitable institutions cannot bring patients to dispensaries if their time is wasted by prolonged waiting on the dispensary benches. The dispensary receiving patients by appointments is bound to have the closest relations with the charitable institutions of the city and to be a great asset as a medical clearing house.

The methods by which dispensaries are conducted at present are medieval and barbaric and probably are not different now than they were hundreds of years ago. When dispensaries manned by "full-time" staffs receive patients by appointment the dispensary will have suddenly undergone an evolution into an institution which will be of the greatest usefulness to the community. At the same time a substantial step will have been made toward the socialization of medicine.

OUT-PATIENT WORK IN OPHTHALMOLOGY

As many problems represented by out-patient work in eye clinics have been brought to the attention of the Associated Out-Patient Clinics it was deemed advisable to call a meeting of the ophthalmologists representing the member institutions of the Association and to organize a section on ophthalmology for the purpose of considering these matters. Such a section was organized in January, 1922, at which time Walter E. Lambert, M.D., was elected chairman; Edgar S. Thomson, M.D., vice chairman; Conrad Borens, Jr., M.D., secretary; and Michael M. Davis, Jr., executive secretary. The executive committee was appointed as follows: Drs. Ellice M. Alger, Isaac Hartshorne, P. Chalmers Jameson, H. H. Tyson, J. M. Wheeler, Julius Wolff, and the officers.

At the several meetings of the section, consideration was given to various topics, such as:

1. Lack of professional standards.
2. Paucity of equipment.
3. Overcrowding in all clinics, especially for refraction.
4. Abuse of clinic by patients able to pay.
5. Failure of patients to secure glasses when prescribed.
6. Unsatisfactory financial arrangements with opticians.
7. Lack of uniformity of fees charged for admission, drugs, laboratory examinations, glasses.
8. Lack of organization for research.
9. Incompleteness of records and inadequacy of filing systems.

The section decided that no official pronouncement on these matters would carry weight unless sufficient facts were gathered upon which to base recommendations. The executive committee, therefore, outlined the research which was considered necessary and the following studies were made: Conrad Berens, Jr., M.D., assisted by Ray A. Losey, M.D., made a study of professional methods, equipment, records, teaching and research in nine institutions, (New York Eye and Ear, Brooklyn Eye and Ear, Knapp Memorial, St. Luke's, Post Graduate, Vanderbilt Clinic, Manhattan Eye, Ear and Throat, Cornell Dispensary and Health Department Clinic at P. S. No. 30). Information was also secured as to the practice in these matters in representative clinics in other cities. A series of records was studied at each institution to ascertain their completeness from a scientific standpoint.

Studies of the admission procedure, fee systems, and the provision of glasses in four special eye clinics and eight eye clinics in general dispensaries were made by Gertrude E. Sturges, M.D., of the staff of the Associated Out-Patient Clinics.

In order to ascertain the need for systematic follow-up systems in eye clinics, a study was made of 5200 records from five representative clinics. The number and proportion of cases which might lead to blindness was determined and the care and disposition of these cases by the clinic was considered.

A summary of the findings of the studies together with the conclusions and recommendations arrived at by the committee as a result of these findings will be presented in the report of the section which will be available in the fall.

PREPARE OUTLINE OF FOLLOW-UP WORK

A tentative outline of follow-up work in an out-patient clinic has been prepared for consideration by the Associated Out-Patient Clinics of New York City. The outline as worked out follows:

1. The physician of the clinic is responsible for deciding at each visit of the patient whether or not the case is to be closed and the patient discharged, or whether the patient should return for treatment, and if so, when.

2. The physician is responsible for instructing the patient, or seeing that the nature of the trouble and the importance of continued treatment is sufficiently explained to the patient to render likely the patient's return.

3. Entry should be made on the medical record of the decision reached under point I, namely, either an entry of discharge, or of the date of desired return.

4. A date index should be kept, showing each patient's name filed under date of expected return.

5. Patients not returning on the indicated date, or within a specified period thereafter, should have their records reviewed to determine whether they should be followed up by mail or by personal visit, or whether the case shall be dropped. This decision shall be made in each case by the physician, or according to rules approved by him.

6. Subject to the above, follow-up letters or postal cards should be under the supervision of a trained social worker, as well as the follow-up by home visits; but so far as possible, the clerical work itself shall be delegated to a clerk.

7. The results of the follow-up shall be reported monthly, indicating the total number of cases received in the clinic; the number and percentage discharged; the number and percentage not returning for treatment; the number and percentage followed up by the various methods; and the number and percentage returning after follow-up.

8. The follow-up system may be applied to an entire clinic, or only to selected diagnoses. It is desirable to apply the system completely to a specific group or type of cases, rather than partially to a larger group.

Adv. page 46

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EVERYWHERE hospitals are proclaiming their approval of the special packing of KNOX SPARKLING GELATINE in one and five-pound cartons.

Recognized by dietitians, physicians and food authorities as the standard of purity for over 30 years, this special packing of Knox Gelatine, in one and five-pound cartons, makes it additionally desirable for hospital use.

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is not alone used as a protein sparer but its value as an appetizing conveyor of nutritious foods and in the preparation of desserts and salads is pre-eminent.

Write for special hospital quotations on quantity purchases of the one and five pound cartons.

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Meetings, Conventions and Conferences

PROGRAM OF AMERICAN HOSPITAL ASSOCIATION CONFERENCE TAKES SHAPE

PRESIDENT George O'Hanlon has released the following tentative program of the twenty-fourth annual conference of the American Hospital Association to be held in Atlantic City, September 25-28. Additions, and a few alterations, are being made weekly in the program which will be published in full in the September issue of THE MODERN HOSPITAL.

Monday Morning, September 25

Registration

Monday Afternoon, September 25

2 p. m. Opening general session
President, George D. O'Hanlon, M.D., presiding
Invocation
President's Address
George D. O'Hanlon, M.D.
Report of trustees
Executive secretary
Report of treasurer
Robert J. Wilson, M.D.
Report of executive secretary
A. R. Warner, M.D.
Report of membership committee
Chairman, Walter H. Conley, M.D., superintendent, Metropolitan Hospital, Welfare Island, N. Y.
Second report of committee on forms and records with particular reference to annual reports
Opening business
4:30 to 6 p. m. Study of exposition

Monday Evening, September 25

8 p. m. General session and section on construction
President George D. O'Hanlon, M.D., presiding
Chairman, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago
Report of special committee on floors
Chairman, Frank E. Chapman
Report of exposition committee on buildings—construction, equipment and maintenance
Chairman, S. S. Goldwater, M.D.
Round table discussion—construction section
Chairman, E. S. Gilmore, presiding

Tuesday Morning, September 26

9 a. m. General session
President George D. O'Hanlon, M.D., presiding
Reports of exposition committee
General furnishings and supplies
Chairman, Harold W. Hersey, M.D. of the Joint Administrative Board, Columbia University and Presbyterian Hospital, New York
Discussion
Clinical and scientific equipment and supplies
Chairman, A. B. Denison, M.D., assistant director, Lakeside Hospital, Cleveland
Food and food equipment
Chairman, C. W. Munger, M.D., superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.
Discussion
Laundry equipment and supplies
Chairman, W. P. Morrill, M.D., Superintendent, Shreveport Charity Hospital, Shreveport, La.
Discussion
11 a. m. to 2:30 p. m. Committee meetings, study of exposition, and lunch

Tuesday Afternoon, September 26

2:30 p. m. Section meetings
Dispensary (in the theater)
Chairman, John E. Ransom, superintendent, Michael Reese Dispensary, Chicago
Dietetics (in the convention hall)
Chairman, Miss Lulu G. Graves, supervising dietitian, Mt. Sinai Hospital, New York
4:30 to 6 p. m. Study of exposition

Tuesday Evening, September 26

8 p. m. General session
President George D. O'Hanlon, M.D., presiding
Report of special committee on renovation of gauze and standard dressings
Chairman, A. B. Denison, M.D., assistant director, Lakeside Hospital, Cleveland
Address—"The Liability of the Hospital"
John A. Lapp, managing editor, *The Nation's Health*, Chicago
Report of dispensary committee
Chairman, John E. Ransom, superintendent, Michael Reese Dispensary, Chicago
Report of legislative committee
Chairman, C. G. Parnall, M.D., medical director, University Hospital, Ann Arbor, Mich.

Wednesday Morning, September 27

9 a. m. Section meetings

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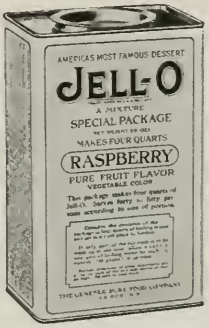
"America's Most Famous Dessert"



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makes one gallon

AND it is so acknowledged, particularly since there has come to be such a general understanding of the value of a sane diet in the preservation of health.

Jell-O is a sweet but not an added burden to digestion. It exactly fills the need of the adults who have come to the point of taking a little better care of themselves, or of the family that does not care to serve food in which children cannot join the grown-ups.

The Genesee Pure Food Company
Two Factories
LeRoy N. Y. *Bridgeburg, Ont.*

Social service (in the theater)
Chairman, Miss Mary S. Wadley, social service department, Bellevue and Allied Hospitals, New York
Trustees (in the convention hall)
11 a. m. to 2:30 p. m. Committee meetings, study of exposition, and lunch

Wednesday Afternoon, September 27

2:30 p. m. Section meetings
Nursing (in the theater)
Chairman, Miss Laura R. Logan, superintendent of nurses, Cincinnati General Hospital, Cincinnati, Ohio
Administration (in the convention hall)
Chairman, C. G. Parnall, M.D., medical director, University Hospital, Ann Arbor, Mich.
4:30 to 6 p. m. Study of exposition

Wednesday Evening, September 27

8 p. m. General session
President George D. O'Hanlon, M.D., presiding
Report of nomination committee
Chairman, D. L. Richardson, M.D., superintendent, City Hospital, Providence, R. I.
Appointment by president of three tellers for the voting
Report of constitution and rules committee
Chairman, Richard P. Borden, trustee, Union Hospital, Fall River, Mass.
Program

Thursday Morning, September 28

9 a. m. General session
Program
11 a. m. to 2:30 p. m. Committee meetings, study of exposition, and lunch

Thursday Afternoon, September 28

2:30 p. m. Round table (in the theater)
Chairman, Asa S. Bacon, presiding
Program
4:30 to 6 p. m. Study of exposition

Thursday Evening, September 28

8 p. m. Closing general session
Announcement of election results
Reports of any other committees
Program
Closing business
The new president, Asa S. Bacon, takes the chair
Announcement of committee appointments
Address—"The Association for Next Year"
The new president
Adjournment

Friday, September 29

Program of scheduled visits to hospitals and special demonstrations in both New York and Philadelphia

Saturday, September 30

Program of scheduled visits to hospitals and special demonstrations in both New York and Philadelphia

PROTESTANT HOSPITAL ASSOCIATION ISSUES TENTATIVE PROGRAM

Pliny O. Clark, president of the Protestant Hospital Association, has announced the following tentative program for the annual conference which will be held in Atlantic City, Sept. 23-25 in connection with the twenty-fourth annual session of the American Hospital Association:

Saturday, September 23

First Presbyterian Church

1:00 p. m. Invocation
1:15 Address of welcome
President, Ministerial Union, Atlantic City
1:20 Response
1:25 General secretary's report
1:45 President's report
2:00 "The Church Hospital—Its Support"
"The Church Hospital—Its Administration"
"The Church Hospital—Its Vision."
Business session.

Saturday Evening, September 23

First Presbyterian Church

Round table discussion led by Dr. C. S. Woods.

Sunday, September 24

Special morning services in all churches
Afternoon session (place to be announced)
The Gospel of Healing
By representatives of all churches.

Monday, September 25

First Presbyterian Church

8:30 a. m. The school for nurses
The diet kitchen
The steward's office
The place of the chaplain
The O. P. D. and the church
The staff
How to Secure Hospital Publicity
Business.

NATIONAL SOCIAL WORKERS CONVENE AT PROVIDENCE

The forty-ninth annual meeting of the National Conference of Social Work was held at Providence, R. I., June 23-29. The meeting was characterized by a large attendance, frank discussion of all topics and an evidence of growing professional consciousness.

The spirit which marked the convention was well expressed in the presidential address of Robert W. Kelso on "Changing Fundamentals in Social Work." The change of ideals in the various fields of social work, he declared, is toward the recognition of the spiritual value of the individual and toward the acceptance of a philosophy of responsibility of the community to the individual as well as the individual to the community.

Owen R. Lovejoy in masterful address on "The Standards of Living and Labor" before the convention declared that the public conscience toward these problems is measurably developing and we are at least "headed forward to a day when a nation can feed, clothe and house itself without destroying any of its people or any other people in the process."

Various divisional meetings were provocative of interesting discussions; among them mental hygiene, public health, treatment of delinquents, community organization, industrial problems, etc.

Homer Folks of New York was chosen president of the conference for the coming year. The fiftieth or jubilee meeting is to be held in Washington, D. C.

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ARTIFICIAL breezes produced by an electric fan motor create a perfect circulation of fresh air throughout hospital rooms, and displace the heavy heat with an atmosphere thoroughly cooling and invigorating.

Some of the most progressive hospitals throughout the country are employing the Taxifan as a means of service. It is artistic in appearance, rigidly constructed, systematic and reliable in its operation. It is economical to patients—profitable to the hospital.

The outstanding feature of the Taxifan is its coin attachment. Its base contains a slot for the insertion of nickels, a money-vault, and a register which accurately counts intake. It will run one hour for each nickel deposited, continuously or intermittently, as desired by the patient. Five nickels at a time, one after the other, may be passed through the slot to obtain a continuous five-hour run.

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HOSPITAL SOCIAL WORKERS HOLD PROFITABLE ANNUAL CONFERENCE

THE American Association of Hospital Social Workers held its fourth annual meeting in conjunction with the National Conference of Social Work at Providence, R. I., June 22-29. The meetings were well attended, from 150 to 200 workers from different parts of the country being present.

Of special interest was the meeting on June 22 when Dr. Joseph H. Pratt of Boston presented a paper on "The Principles of Class Treatment and Their Application to Various Chronic Diseases." Speaking from his seventeen years' experience in charge of the Emmanuel Tuberculosis Class, Dr. Pratt made a real contribution by his challenge of the present lack of differentiation of the terms, class treatment, group treatment and special clinic.

Dr. Pratt proffered his definition of each as follows: "A class in this specific sense implies instruction of some sort. To avoid confusion let me suggest that we attempt to distinguish between class, group and special clinic. A class may be defined as a group of patients brought together for instruction who are affected with the same disease and under the same plan of medical treatment and supervision. On the other hand, if in a diabetic clinic the instruction were entirely individual it would come in a different category. When the number of patients is not limited, but the work of a clinic confined to one disease, let us term this a special clinic, as a tuberculosis clinic, diabetic clinic, etc. If a group of selected patients meet the physician, nurse or social worker at stated times but are seen individually and do not have the opportunity except by chance to gain from the experience of the other patients and receive no instruction collectively, it would be well to term such an organization a group.

Dr. Pratt gave five conditions which he believed to be essential for success in class treatment:

(1) A physician in charge who has knowledge of the disease and knows how to run a class.

(2) A social worker trained medically and socially who can get results with the patients. She must understand the details of the treatment as well as the physician.

(3) Definite method of treatment that will get results and justify the patient in persistent treatment.

(4) A certain irreducible minimum in the way of financial support.

(5) Small number of patients—ten to twenty.

The discussion by workers from Chicago, Cleveland, Baltimore, New York and Boston bore testimony to the increasing use of class method in treatment of chronic disease.

On June 23 an audience of about 300 listened to the discussion of the training for hospital social work, with Miss Katherine McMahon of Boston as chairman of the meeting.

Code of Ethics for Social Worker

Dr. A. J. Todd, formerly professor of sociology of the University of Minnesota, was the principal speaker at this meeting. Dr. Todd presented in his paper the subject of training for social case work, not specifically as applied in hospitals but as a fundamental basis of common training for all specialists in social case work. Dr. Todd said that all professional training includes: first, a mastery of principles; second, acquirement of technical skill; and third, a code of conduct.

Dr. Todd emphasized the value of a broadly cultural education in subject matter which is not immediately useful in the practice of one's profession and said that it was largely the possession of a philosophical background which made the difference between the professional social worker and the mere craftsman. In speaking of the importance of a professional code of conduct, Dr. Todd reported an analysis which he had made of the reasons for which social workers had been dismissed from their positions in twenty-five cities and found in 20 per cent of cases the reasons were ethical, including immorality, inability to do team work, disloyalty, indiscretion, dishonesty and "slacking." He summed up the ethical code of the professional worker as including truth, seeing the job through, cooperation, promptness in meeting obligations and a "decent" reticence.

Urges Post Graduate Courses

Miss Mabel Wilson of the Children's Hospital of Boston followed Dr. Todd and made the application of his general principles to special training for hospital social work. She advised the throwing back of certain basic and preliminary courses into undergraduate education and the development of a post graduate course of technical training with supervised practice. Miss Wilson feels that the time usually allotted to practice in the courses as they are now given in schools of social work is subdivided into periods which are entirely too short and is as a whole, inadequate. She would like to see the development of a continuous practice period of several months' duration.

Dr. Kenworthy from the New York School of Social Work, herself a practicing psychiatrist and teacher of mental testing, spoke on the part played in social case work by an understanding of the mechanisms and principles of human behavior. Her paper was a convincing argument for the inclusion of courses in behavior as an essential part of training for social work in general and for medical and psychiatric social work particularly.

Miss Mary Antoinette Cannon spoke of the advance that had been made within the past year in the formulation of concepts of organized medicine and of social case work, especially as expressed in the recent report of the Rockefeller committee on education of hospital administrators and in Miss Richmond's recently published book, "What is Social Case Work?" The hospital social worker is in a better position on account of these two contributions to formulate a clear definition of the functions and necessary equipment for hospital social work. She spoke of some details in regard to the planning of medical-social training courses which had been brought out by her work during the past year with the American Hospital Association committee on training.

On June 24 a joint meeting was held by the hospital social workers with the American Association for Organizing Family Social Work. Mrs. John M. Glenn acted as chairman.

Miss Ann Estabrook of Boston was the first speaker. She discussed the mechanics of registration, refer and transfer, principles underlying the assignment of problems to the two special fields of social work, medical and family, and some method in use of maintaining intercom-

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"A silence almost oppressive," is the way one nurse described it. Mount Sinai Hospital at Cleveland had just been treated with Johns-Manville Acoustical Correction. From being a hospital about as noisy as the average, it is now one of the quietest.

Mount Sinai Hospital, Cleveland, Ohio

A service for making hospitals quiet

Noise in a hospital is anathema. Yet, for sanitation, fire protection and durability, the modern hospital must employ building materials which by their nature multiply sound. To offset this reverberating property, Johns-Manville has developed a treatment for ceiling and walls which absorbs sound. This treatment, of long proved effectiveness, is of special importance to hospitals.

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Acoustical Correction deadens noise because it absorbs the sound waves. A specially prepared acoustical felt is used. This felt is applied against the ceilings or upper wall surfaces of rooms and corridors. It is then covered with a tightly stretched membrane and treated with a sanitary coating.

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Acoustical Correction

munication between workers in the two fields. Her conclusions in abbreviated form are: "(1) Although we ask different things of each other, what we ask is social in each case. (2) Medical and social elements are closely interwoven. The family worker must hold in balance family and community interests; the hospital worker, a part of her institution and responsible to her for what she does and leaves undone for her patient must concentrate on those social elements involved in the sickness of the individual. (3) A thorough understanding of the patient and a thorough understanding of each other's attitude in the individual case will make policies that are strong enough to fall back upon in the ordinary routine of our inter-relation; also flexible enough to adapt them to various individual needs."

Mr. Frank J. Bruno of Minneapolis offered three interpretations of the function of the social worker in the hospital:

(1) The medical social worker may be the agent of the physician. (2) He may be an adjunct of the administration of the hospital. (3) He may work on a parity with the physician, assuming any social problem presented by a patient and carrying out whatever is necessary to be done throughout all its implications. Mr. Bruno thought that the social service department of the first type served as a barrier between the family agencies and the physicians in the hospital and was likely to force the family agency, in its most difficult cases, to seek medical help where the family social worker could have direct access to physicians.

A delightful luncheon was given the visiting hospital social workers on June 27 at the Rhode Island Hospital through the courtesy of the superintendent, D. J. Peters.

At the annual business meeting the following officers were named: Miss M. Antoinette Cannon, president; Miss Margaret Brogden, treasurer; and Miss Lena Waters, secretary.

DIETITIANS ANNOUNCE TENTATIVE CONVENTION PROGRAM

The American Dietetic Association is to hold its annual convention at the New Willard Hotel in Washington, D. C., October 16-18. On the 19th a day's visit and program at Johns Hopkins Hospital in Baltimore have been planned for those who wish to visit this interesting city and famous hospital.

The program for the meeting is not complete as yet, announces Miss Octavia Hall, chairman of the program committee; however, the following persons have consented to speak: Dr. J. P. Watson, psychologist; Dr. Elliot P. Joslin of Boston; Miss Emma Gunther of Teachers' College, Columbia University; Mrs. Mary D. Bryan, president of the American Dietetic Association. Major Stimpson will be among the speakers on the first day. The tentative program of the convention includes addresses by the following:

On Tuesday: Dr. Alfred Hess of New York; Miss Stewart, assistant dietitian, Ann Arbor Hospital; Dr. Leroy E. Parkins, assistant superintendent, Peter Bent Brigham Hospital; Mr. Henry C. Wright of New York, Mrs. Mary Swartz Rose of Teachers' College, Columbia University, New York.

On Wednesday: Miss Ida M. Cannon of Boston; Miss Lucy Gillett of New York; Miss Louise De Planter of Philadelphia; Dr. Walter Cannon, professor of Physiology, Harvard Medical School, Boston; Miss Lulu Graves, superintendent of the dietary department, Mt. Sinai Hospital, New York; Miss Marjory Hulsizer, dietitian, Barnes Hospital, St. Louis, Mo.; Miss Daisy Treen of the Women's Educational and Industrial Union, Boston; Miss Mary Lindsey of the Grace Dodge Hotel, Washington, D. C.

Thursday in Baltimore: Dr. E. V. McCollum and Dr. William S. McCann of Johns Hopkins Hospital.

A number of special features are being planned this year. The Washington dietitians are arranging for some trips and social events and one evening of the meeting will be interesting especially as it will be an "all-member program."

SUGGESTED PROGRAM OF AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The suggested program of the American Occupational Therapy Association convention to be held in Atlantic City in September in conjunction with the twenty-fourth annual conference of the American Hospital Association has been outlined by Dr. William Rush Dunton Jr., chairman of publicity and publications of the association.

The first day's session will be held with the opening session of the American Hospital Association. A discussion of occupational therapy in general hospitals will be presented from various angles: its value, its cost, ward use and dispensary use. Each topic will be introduced by a twenty-minute talk. Opportunity for open discussion will follow.

Reports of occupational therapy as carried on in Massachusetts, Connecticut, Pennsylvania, Maryland, Illinois and other localities and by the United States Public Health Service and Veterans' Bureau will take up an entire session. A round table upon records will be conducted by Dr. Horatio Pollock.

The financial side of occupational therapy in state hospitals, in incorporated hospitals, sanatoriums for tuberculosis and hospitals for mental and nervous diseases will be considered broadly during one of the morning sessions. The afternoon session of that day will have to do with a discussion of crafts and their therapeutic value. This topic will be discussed from the following standpoints:

1. For mental diseases.
   a. Acute
   b. Chronic
2. For nervous diseases.
   a. Acute
   b. Chronic
3. For the tuberculous.
   a. Acute
   b. Chronic
4. For the crippled.
   a. Acute
   b. Chronic
5. For bed patients.
   a. Acute
   b. Chronic

PUBLISHES MANUAL FOR NURSES

St. Mary's Hospital, Milwaukee, has undertaken an interesting work in cooperative publishing which is meeting a wide response from hospitals of America. A manual, known as the "Marillac Guide," is being put out by the hospital in cooperation with other institutions which may substitute within its pages individual regulations.

For many years, St. Mary's Hospital has maintained an efficient nurses' training school. As an outgrowth of her experience there, the superintendent several years ago compiled a pocket-sized manual for the use of the student nurse, containing in concise form regulations for charting, signs and symptoms of common diseases, caloric values, symptoms of overdosing from drugs in ordinary use and directions for standard solutions. All of the information is that which must commonly be drilled into the nurse by constant repetition. More than 25,000 copies are now in use in all parts of the country.

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BRITISH HOSPITALS ASSOCIATION MEETS AT LIVERPOOL

Financial problems connected with the voluntary hospitals furnished the dominant topic of discussion at the twelfth annual conference of the British Hospitals Association held on May 25-26 in Liverpool.

Sir Arthur Stanley presided at the sessions and in his opening address before the convention expressed his confidence in the voluntary system. The British public, he believes, has determined that voluntary hospitals are not to give way to the rate system and it will from year to year become more generous in donations. Sir Arthur's ideas on the question seemed to be reflected in the majority of speeches throughout the convention and he was renamed president of the association.

Visits to sixteen local hospitals and infirmaries were paid by the delegates on the closing afternoon of the convention. The school of tropical medicine of Liverpool University also attracted many visitors. The lord mayor of Liverpool entertained for the convention guests at tea at the Town Hall and other dinners and social affairs relieved the routine sessions of business and papers.

The fate of voluntary hospitals rests entirely upon themselves, said Sir Alan Garrett Anderson, K.B.E., in a strong address upon "The Change in Hospital Finance." Sir Alan is an official of King Edward's Hospital Fund which has been appointed as the voluntary hospitals committee of the London area.

"In London," declared Sir Alan, "the great majority of hospitals have decided to tell their patients that an independent working man ought to provide for himself and his dependents in sickness as he does in health and to organize a system under which that provision can be made. They are setting up a company with limited liability, but with no power to make profits, called the Hospital Saving Association, which will invite persons within the hospital income limits to subscribe week by week or year by year the premium appropriate to cover their risk.

"The help the hospital gets from its patients, however, must not scare away charity. In this we are between the devil and the deep sea. If we don't get more income the hospitals will smash and if once the charitable public gets the idea that the voluntary system can't be saved by its subscriptions, the State will be forced to take over hospitals as it has taken over schools.

"This is no time for selfishness—the hospitals must sink or swim together, and so in London all but one of the large hospitals and almost all the small hospitals are united for the first time in the Combined Appeal for money to clear their feet for a time until they can start the contributory system and can increase in other ways the support they get from those who use the hospitals."

The question of whether hospitals should make claims on approved societies in respect to their services to insured persons was a second topic which provoked much discussion. At a call of hands, every member of the association voted for their organization to continue negotiating with the approved societies for funds. It was reported that 250,000 pounds has been set aside by approved societies for distribution to hospitals. Only about half of the hospitals represented at the convention had applied for payment.

A paper by Mr. Frank Hazell, general superintendent and secretary of the Manchester Royal Infirmary, advocated the establishment of a central provincial hospital fund for the benefit of the 650 provincial hospitals. The convention later voted its approval of such a fund formed along the same lines as King Edward's Fund for London. It will be taken up by the association council.

Cooperative buying, the use of oil fuel in hospitals and similar topics were the subject of interest in the discussion.

A. H. A. WILL INVESTIGATE TRANSACTIONS

Any sale of goods to hospitals by exhibitors at the coming session of the American Hospital Association in Atlantic City, which is not in accordance with established customs and standards, will be investigated by the association.

This assumption of further responsibility to hospitals regarding exhibits was decided upon at the June meeting of the American Hospital Association trustees. The association has made a policy of investigating all firms and products appearing in the annual exhibition and this further step was taken to make the exposition of more positive value to the hospitals, especially the institutional members of the association.

The resolution covering this extension in policy which was unanimously adopted is as follows:

RESOLVED: That the executive secretary be and he hereby is authorized and instructed, whenever so requested by any hospital, to undertake the settlement and adjustment of any question arising from the purchase during the convention of any article from any exhibitor at the 1922 convention of the association and to act likewise for any institutional member regarding any purchase from an exhibitor at this convention made during the period between the 1922 and 1923 conventions, the object being to assure to hospitals, and particularly to institutional members, satisfactory results from dealing with those who are permitted to exhibit at the association meetings.

FUNCTION OF A. H. A. EXPOSITION COMMITTEES IS DEFINED

A statement of the function and the desired activities of the exposition committees at the coming annual conference of the American Hospital Association has been drawn up by the board of trustees as follows:

(1) The chairman of each committee will take five to eight minutes of his time in presenting concisely the present standards and consensus of opinions of the best hospital policies in their representative fields.

(2) The chairman of each committee will then take five minutes in outlining that which may be learned by delegates from exhibits with suggestions as to the way to make the best use of the exposition to learn of their line.

(3) The chairman will then briefly indicate the various types of information which will be furnished by the committees in detail to individual inquirers.

(4) At the desk and headquarters, the committee will have such information as it has collected and tabulated on many problems within the field of the committee. Some of these will be worked up into parts and others into tabulations manifolded so that copies may be given to individual members. They will have also reference lists to published articles on various subjects for distribution that questions may be looked up more thoroughly after the convention, but there shall be no definite expression of opinion as to the relative merits of various items of exhibit.

"Why, gentlemen," thundered a parliamentary candidate, "my opponent hasn't a leg to stand on."

"All the more reason why he should have a seat," came a voice from the rear.—*The Medical Standard.*

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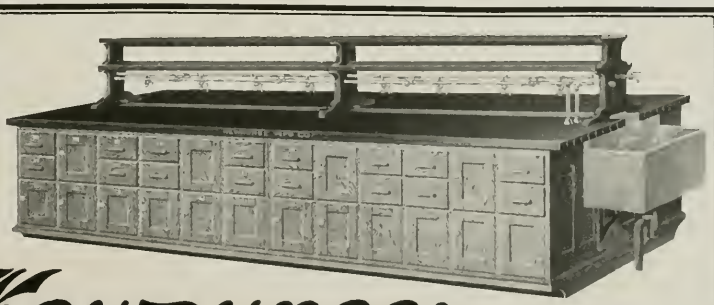

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QUERIES AND ANSWERS

IS CONTINUOUS SERVICE DESIRABLE?

To the Editor of THE MODERN HOSPITAL:

Some hospitals are connected with medical colleges; others are not. It is contended that while continuous service is desirable for medical college hospitals, it is not necessary for a hospital which is not connected with a medical school. Is this a correct view?

SUPERINTENDENT.

From the standpoint of clinical organization, it is more helpful to classify hospitals as staff hospitals and open hospitals than to consider them as hospitals connected or not connected with medical schools, for whether a hospital is connected with a medical school or not, the adoption by the hospital of an aristocratic or exclusive form of medical organization implies an obligation to teach and to aid in the advancement of medical science. To the many learners in the non-college staff hospital, one more group is added in the college hospital, namely, the undergraduate student group; this addition, however, does not fundamentally change the character of the staff hospital or vitally affect its organization. The open hospital, on the other hand, has a distinctly different purpose and significance, and it may well be argued that in this country there is need of both open hospitals and staff hospitals.

One merit of the open hospital is that it brings into contact with an organized medical institution many physicians who under an exclusive staff hospital system would be deprived of helpful and stimulating medical contacts, without which they would be in great danger of deteriorating in medical knowledge and proficiency from the moment of graduation from medical school. Another point in favor of the open hospital is that it enables the paying patient to choose his physician or surgeon with the utmost freedom.

While, however, the open hospital can perform a very useful service, it is of necessity a relatively loose organization, in which uniformity of procedure is almost impossible of attainment, in which the highest standards do not as a rule prevail, and from which the systematic and illuminating study of groups of cases by a well-organized and intelligently directed team of clinicians and laboratory men is ordinarily excluded. The promotion of medical science is essentially a function of the staff hospital, and the most efficient form of staff organization is that in which several clinical departments operate for an unbroken period of years under the leadership of able men, conscientiously chosen by an impartial board.

The hospital in which men holding equal rank as heads of clinical departments rotate in office every three, four or six months offers no warm hospitality to the scientific spirit. Every staff hospital should make constant contributions to medical science and should be organized with this end in view The frequent interruption of clinical leadership and authority is apt to involve a damaging interruption of the progressive study of disease. We have witnessed the actual inauguration of valuable investigations and have seen such investigations continue uninterruptedly under the same leadership for three, five or even ten years. If the improvement of medical science be one of the acknowledged objectives of a staff hospital, there is much to be said against and very little in favor of an interrupted or rotating service.

It is true that uninterrupted service too long continued has its disadvantages and that the hospital in which the continuous service, so-called, prevails should do everything possible to guard against the danger of continuing in office the head of a department who has ceased really to guide and inspire his subordinates. While, therefore, continuous service is desirable, the possibility of interrupting it for adequate reasons should be safeguarded. This can be done by the automatic retirement of heads of service by means of a prescribed age limit, by limiting the official term of the head of any service (a five-year limit, which some have suggested, is too short; a term of not less than ten and not more than twenty years is preferable), and by making all staff appointments for limited periods of, say, two or three years subject however to renewal up to the limits of the maximum term referred to above, or up to the pre-established age limit.

S. S. GOLDWATER, M.D.

COST OF A CHILD'S ROOM

To the Editor of THE MODERN HOSPITAL:

What information can you give me as to the cost of equipping and maintaining a single room in a hospital to be used for the care and treatment of children? I wish to know, first, the cost of equipping such a room and, second, the cost of maintaining it, including such factors as medical service, nursing, food and maintenance, and depreciation. SUPERINTENDENT OF HOSPITAL.

It would cost probably $250 to $500 to furnish a private single room for the care and treatment of children, according to the quality of equipment. The former figure would furnish all the necessary equipment of first class quality for a room to be used for ward patient; for private patients it is possible to pay any price you desire.

As to maintaining such a room, it would cost approximately $5 a day if for the use of ward patients, and $10 a day if for the use of private patients. The first figure includes medical care; the second does not; neither includes depreciation.

God asks no man whether he will accept life. That is not the choice. You must take it. The choice is how.—Beecher.

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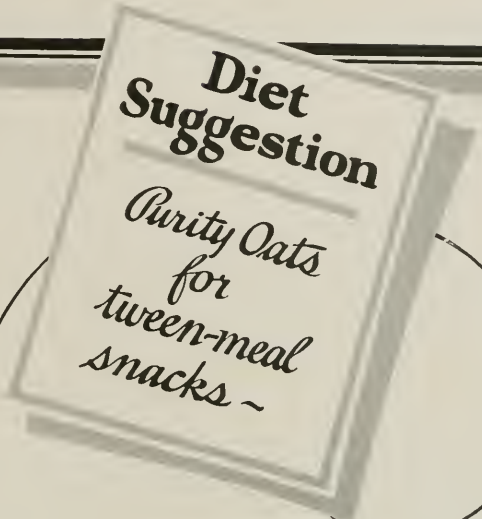

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FOREIGN CORRESPONDENCE

THE FUTURE OF BRITISH HOSPITALS

(From Our London Correspondent)

A REMARKABLE address on the hospital situation in Great Britain was given by Mr. J. H. Waring, surgeon and joint lecturer in surgery at St. Bartholomew's Hospital, in the rooms of the Medical Society of London recently.

Mr. Waring said that since the establishment of most of the voluntary hospitals in this country, the benefits of those institutions in regard to investigation and treatment are limited to the necessitous poor, while their doors are closed to those who have provided or contributed toward the funds. Practically, the result is that the necessitous poor are much better provided for than the upper and middle classes and public hospitals are far better built and equipped than private hospitals. The general public during recent years has become cognizant of this fact, and, he observed, during the past decade a gradually increasing demand on the part of the non-necessitous for means or facilities of entrance as patients to the voluntary hospitals has arisen. That is due to the fact that the laity has begun to recognize that the diagnosis and treatment of disease with expedition and the likelihood of obtaining the best results can only be satisfactorily carried out in a properly built and equipped institution, clinic or hospital, and that for the most part our so-called private hospitals and nursing homes are merely adapted, mediocre, second-class private dwellings.

In the past the well-to-do and rich classes of Great Britain have been quite satisfied with, and even preferred to go into, small nursing homes or so-called private hospitals, because they thought they would get in such places what they looked upon as home comforts, and also because of a prejudice against public hospitals which has survived since the pre-aseptic days. Now that the scientific principles of cleanliness are better understood and the internal conditions of hospitals known, people are beginning to realize that their prejudice against public medical institutions is unfounded and that they are more likely to get better investigation and treatment in a hospital or public medical institution than elsewhere.

Outlines Benefits of New System

This change of opinion has also been expedited and assisted by the increasing number of English people who live in tenements, flats or apartment houses. It is now generally admitted that the medical treatment of patients in hospitals should be of the same high level for all; both rich and poor. Therefore, taking into consideration, the present trend of public opinion and the changing conditions under which we live, hospitals ought to be adapted to modern needs and requirements. The advantages which will be gained by the provision of a department for paying patients in a general charitable hospital, Mr. Waring summarized as follows:

To patients.—Members of the upper and middle classes will obtain institutional investigation and treatment of the same high standard as they provide, or assist in providing, for the necessitous poor.

To hospitals.—The special departments both for investigation and treatment can be more fully and continuously utilized than is done at present, especially in those hospitals where such departments are only open on two or three days, or half-days per week. The overhead charges for general administration will not of necessity be increased, or, in any case, not proportionately increased. Therefore, a portion of such charges can be legitimately transferred to the paying department and consequently each paying department can be made a source of profit to the hospital.

To staffs.—Members of the staffs of the hospitals will be able to have some of their patients in the private or paying department and thus save themselves considerable time in going from one private hospital or nursing home to another. Resident medical officers can be appointed to a paying department of that kind, and their services will be valuable in the absence of the medical man under whose care and treatment they were. The advantages provided by a paying department, will, he thinks, be most appreciated in connection with maternity and surgery. At the present time the mortality in maternity cases is little different than in pre-aseptic days. That is a serious reflection on present methods. Government and departmental measures appear to be very much to blame for the very limited and inferior accommodation in that respect. The government seems to be much more interested in the survival and preservation of the unfit than in the promotion of measures for the preservation and survival of the fit. The too liberal dispensation of medicines and drugs is one direction in which he thinks many of our hospitals err.

The dental departments of our general hospitals in many instances are defective owing to the small amount of space alloted to them, and the practice which obtains in many of them of sending the patients to special dental hospitals for treatment.

In commenting upon Mr. Waring's suggestions it may

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be pointed out that the British and American modes of viewing the hospital question are essentially different. The British man or woman, medical or lay, is bound by tradition to an extent hardly intelligible to an American. He or she has been accustomed for generations to the voluntary system which until put to the strain of modern conditions and war has answered well. The British are by instinct and training conservative, averse to innovations, at least, so long as such innovations have not been proved beyond peradventure to be beneficial.

Therefore, the proposal put forward by Mr. Waring, and which has been advanced previously by others, notably by Sir John Macalister, secretary of the Royal Society of Medicine, that the general charitable hospitals should establish departments for paying patients, is regarded if not quite with suspicion, at any rate, as a matter which requires careful consideration in many of its aspects. However, it now appears that the governing bodies of the London hospitals approve of the suggestion in principle. But it is assumed that such a scheme is not intended to involve the withdrawal of any of the accommodation now maintained in the interests of the poorer classes of the community and its utilization for the benefit of another class. Therefore, separate establishments will be necessary for paying patients, but their provision must not impose any burden upon hospitals whose funds are even now inadequate to the fulfillment of their existing obligations.

The hospitals are bound to maintain a certain number of beds consecrated to the necessitous poor, and they are striving to raise the funds to enable them to discharge these obligations. If, consequently, departments are to be provided for paying patients, the hospitals must be financed for the purpose. Attention is drawn to the fact that in America everybody, rich and poor, goes to the hospital, and gets the advantage of organization and the highest medical skill. Beds are provided according to the capacity of the patient to pay and the more wealthy are able to obtain luxurious accommodation.

It is considered by the London hospital authorities that it is some such system that Mr. Waring has in view, and that sooner or later it will be adopted in Great Britain. Yet, as said before, if special accommodation is to be provided for paying patients, considerable expenditure of capital will be necessary.

AN EMBLEM FOR HOSPITAL SERVICE

A red cross tells its own story. So also does the double-barred cross.

To obtain for hospital service and the American Hospital Association an official insignia which will meet the instant recognition universally accorded the emblems of the International Red Cross and the National Tuberculosis Association, the board of trustees of the American Hospital Association in its June meeting took the first step.

The trustees have authorized President George O'Hanlon, M.D. of the association to appoint a committee "to devise methods of procedure for the creation and adoption of an insignia to mean hospital service and to be generally used, and also some appropriate modification thereof to be used as the seal and official insignia for the American Hospital Association, and also if practicable suggest other modifications of this insignia to be used generally by individual members."

The book of Nature is that which the physician must read; and to do so he must walk over the leaves—Paracelsus.

LETTERS TO THE EDITOR

HIRING EMPLOYES IN CITY HOSPITALS OF NEW YORK

To the Editor of THE MODERN HOSPITAL:

Your editorial upon the liability of trustees for negligence of incompetent employes has been referred to me and I have read it with great interest. I concur with the Supreme Court of Ohio in regard to its statement, but I must say that unless the court recognizes the superintendent of the hospital as being the proper person to determine whether or not an applicant for a position is competent to fill it, it would be a very unjust law.

This timely warning by THE MODERN HOSPITAL to trustees and superintendents of their responsibility in the selection of employes in the hospital is one for which every member of our particular branch of professional work should be thankful. Furthermore we should base our procedure, in the employment of hospital help, upon the basis that some time we may be called upon to show evidence in a damage case against the city for negligence in the part of the hospital or some one connected with it.

At the present time in the city of New York the responsibility for the selection of a considerable number of employes rests upon the Civil Service Commission which provide them to the city departments through eligible lists established by competitive examinations. There are, however, a large number of non-competitive positions which are filled by the superintendents of city hospitals who certify to the Civil Service Commission as institutional examiners that they have made a careful examination of the employes and forward to that body, in the case of responsible position, a special blank for each person so employed. This method of procedure is a great protection to our city and a procedure of like character might well be adopted by private institutions making the reports that were sent to the Civil Service Commission returnable to the board of trustees for its information and consideration.

Thanking you for an opportunity of reading this editorial.—ROBERT J. WILSON, Director Bureau of Hospitals, Department of Health, City of New York.

A. H. A. VOTES ANNUAL SUBSCRIPTION TO LIBRARY AND SERVICE BUREAU

At the June meeting of the board of trustees of American Hospital Association $1,000 was appropriated from the general fund of the association to the use of the Hospital Library and Service Bureau, located at 22 East Ontario Street, Chicago, for its maintenance in the fiscal year ending July 1, 1923. In the same resolution authorizing the appropriation the trustees expressed their willingness to give consideration to the need for an additional appropriation from the association to the Library and Service Bureau during the same fiscal year.

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The fact of the matter is, a hospital is not strictly modern unless it is equipped with The Johnson Pneumatic System of Temperature Regulation. And the word modern here does not mean merely luxury, refinement, or simply new ideas; but the very latest improvements for temperature control, obtaining the utmost convenience, performance perfection, the very minimum of maintenance and fuel consumption cost: thorough efficiency throughout.

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Book Reviews and Current Hospital Literature

THE LIFE OF CLARA BARTON

By William E. Barton, Author of "The Soul of Abraham Lincoln," "The Paternity of Abraham Lincoln," etc. With illustrations.[1]

If biography contains no inspiration, it must meekly ask pardon for its existence. No such apologetic attitude need be assumed by the biographers of Clara Barton. The woman who earned for herself such titles as "angel of the battlefield," and "mother of the American Red Cross" could scarcely have pursued a course barren of influences stimulating to others, but the achievements of Clara Barton take added significance and value when one reads of her long struggle against certain innate handicaps.

In the two-volume work, entitled "The Life of Clara Barton," fresh from the pen of her kinsman, William E. Barton, a distinguished clergyman and the present moderator of the Congregational Churches of America, posterity is given intimate access to an active and picturesque life. This woman, in the days when her sex was hampered by silly convention and by lack of political status, abandoned her school-room domain and by sheer force of will and love for humanity made unobtrusive entry into the high seats of government and the shifting battle-line of a civil war.

Clara Barton knew personally every president from Lincoln to Roosevelt and was acquainted with nearly every prominent man in the contemporary life of the nation. When her activities took her abroad, her associates were those of high station and extended influence. No American woman during her lifetime received greater honor, and none bore honor more worthily. These facts history records, as well as her biographers.

But of her private life, her natural endowments, her unconfided thoughts we read with fascination in the new "Life of Clara Barton." Her diary, the autobiography of her childhood, personal letters, official papers—the lifetime accumulation of a person who destroyed nothing—have been sifted by her biographer to produce an exact picture of his renowned woman relative.

Three characteristics of Clara Barton seem to surmount the others: her natural reticence, which amounted in childhood to a supersensitiveness almost neurotic; her unfailing energy and determination; and her love for humankind.

Of her childhood days Miss Barton wrote once that she remembered nothing but fear. So timid was she that her parents despaired of her making any progress in study with other children. On a visit she made unaccompanied, she was afraid to eat and had to be taken, weak and pale, back to her family. When by chance she witnessed the killing of an ox by her father's farm hands, it so effected her that throughout her long life she never ate meat, unless the refusal to do so brought embarrassment to those about her. The child who quailed at a thunderclap did not grow, without a relentless mental struggle, to the woman who advanced with the "boys in blue" into the fury of enemy shells and nursed the wounded and dying of both North and South while the bullets grazed her body and spattered her with the blood of their victims.

But the timid child by stern mental discipline grew into a more self reliant young woman, who in her late teens took up the family profession of teaching and for twenty years kept school with increasing reputation for administration and scholarship.

Clara Barton was in Washington on April 15, 1861 when Lincoln issued his call for men and she read aloud to the homesick Massachusetts soldiers quartered in the august chambers of the U. S. Senate. From this first call to arms, one sees Clara Barton, the indefatiguable. Convention, refusals, rebuffs, delays—nothing—hindered her in bringing what relief she could to the wounded armies. Her energy never waned, her resourcefulness never failed her, her persistence always achieved her end. This woman, who at ninety learned to run a typewriter and took lessons in tree-grafting, was during the Civil War in her prime of energy and unselfish devotion.

After Appomatax, there began for Miss Barton a new struggle. At Geneva, Switzerland, was being formed the International Red Cross, the materialization on a world scale of what she had long striven and prayed for in America. The United States Senate did not oppose the League of Nations more bitterly; for eighteen years Miss Barton fought for the American ratification of the Geneva treaty before it was finally passed and this nation became a member of the organization "whose record in the great World War shines bright against that black cloud of horror, as an emblem of mercy."

"The Life of Clara Barton" is not merely a book of inspiration for nurses, for women and for those interested in the battles which won the Civil War and the American acceptance of the Red Cross treaty. It is that, surely. But mainly are its more than 700 pages worthwhile because therein is pictured the battles of a nature against itself and a final victory which emancipated the soul of Clara Barton and won for the United States the right to fly, by the side of the Stars and Stripes, the Red Cross—the emblem of mercy.

1. Houghton Mifflin Company, Boston and New York, 1922.

The title of Miss Amy Pope's "Textbook on Simple Nursing Procedure" was erroneously given in the July issue as "Applied Psychology for Nurses."

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XIX *September, 1922* No. 3

NEW FIFTH AVENUE HOSPITAL EMBODIES STRIKING STRUCTURAL FEATURES

By WILEY E. WOODBURY, M.D., Consultant, New York, N. Y.

BEFORE proceeding with a description of the physical features of the Fifth Avenue Hospital, it seems desirable to say something of the ideals around which this institution has been planned.

For several years prior to the World War, the board of trustees and the members of the medical staff of the Hahnemann Hospital contemplated the construction of a new plant to replace the old structure which had served the public of New York for upwards of fifty years, and after careful consideration it was decided that the new building should be so planned that the ideal type of hospital service would be available for all persons, irrespective of class, creed or color.

Facilities for Patients of Moderate Means

Investigation showed that the hospital problem had been pretty well solved for the extremely poor. The great city hospitals, as well as the privately endowed institutions, provide a modern ward service for those who are unable to pay.

And of course the person of unlimited means can secure a private room with bath, or even suites of rooms, equipped with all the modern conveniences known to hospital practice.

During this investigation the trustees and the members of the medical staff found that there was a great in-between class of people, who should, for their recovery's sake, have the type of hospital service available only to those of independent means.

These people are not well to do, nor are they poor. They do not want charity and they cannot afford luxury. To be placed in a large charity ward or even a pay ward, would be a most depressing experience, and, on the other hand, paying the price for a comfortable private room would mean great financial strain at a time when they should be free from such worries. Then, too, it is the opinion of the members of the medical staff that to give a patient complete contentment of mind is to start him on the road to recovery.

To provide this in-between class with all of the necessary comforts and privacy of a single room is the great ideal around which this hospital has been constructed, but in order that all classes may be accommodated ample provisions have been made to care for the person of unlimited means, as well as for those who are extremely poor.

The rates authorized by the board of trustees are from "nothing up."

It was in accordance with this ideal, that the board of trustees directed the architects, York & Sawyer, together with Marc Eidlitz & Son, builders, and the writer as consultant, to prepare the plans for a single room hospital of three hundred beds capacity.

Central Idea is Concentration

The building, which is nine stories in height, with basement and sub-basement, is constructed on the plan of the letter X, and it is because of this design that each of the three hundred rooms is an outside room.

That the single room idea is one of the most striking features, goes without saying, but it should also be borne in mind that the scheme of organization and administration is of equal im-

portance. To plan a building containing all single rooms, would in itself present no particular difficulties, but when one considers the exacting demands of a modern hospital service, in connection with a building of this character, it is apparent that the scheme for organization and administration must receive special attention.

A glance at the floor plan will show that the idea of centralization of control was uppermost in mind in connection with the scheme of organization of this hospital, and one of the most important features is the central service department, located in the center of the main basement. It is flanked by the main kitchen, the diet kitchen, pharmacy, storerooms, surgical supply department and linen rooms. This central service department will receive all orders from the several floors, by means of the telautograph and the automatic telephone systems. The required articles will be transported by four electric dumb waiters and a large freight elevator, all of which are a part of the equipment of this department.

The surgical supply division will have charge of all sterilizing for the institution. Soiled instruments and dressings from the various floors will be transported by special dumb waiter to what is known as the disinfecting room, and, after having been properly cleaned and disinfected, will be passed into the sterilizing room and finally into the supply department for re-distribution.

The main kitchen and special kitchen provide the food service for the entire hospital. Both of these rooms are lighted and ventilated by artificial means. The general diets are prepared in the main kitchen and transported to the floors by means of electrically heated trucks, each having a capacity of twenty-four trays. The service is direct from the serving table in the main kitchen to the bedside of the patient without rehandling on the floors. Special diets and liquid nourishments are prepared in the special diet kitchen, and the dumb waiter service furnishes the means of transportation between the basement and the upper floors. The dish washing room, located nearby, takes care of all of the dish washing for the entire institution.

In the basement will also be found the locker rooms and dining rooms for maids and porters, storerooms and laundry.

In the sub-basement are located the boiler plant, the fan rooms, the morgue, the autopsy rooms, the disinfecting plant and the incinerator plant.

The first floor contains the administrative offices, the admissions department, the dining rooms for resident house staff and nurses, and living quarters for interns, but on this floor will be found also a special feature in the form of private offices for physicians. In these offices they will be able to receive their private patients, and at the same time will remain in close touch with other patients in the hospital under their care. These suites of offices consist of a private reception room, an office and an examining room, and are so located that visiting patients will be admitted through a private entrance, and will not come into the hospital proper. This arrangement enables the physician to take advantage of the diagnostic facilities of the hospital, the benefits of which will accrue to the visiting patients.

Front view of Fifth Avenue Hospital, showing a corner of Central Park.

Another feature that should appeal to many is observed upon approaching the main entrance and rotunda. Here the visitor will note a complete absence of anything that might suggest a hospital atmosphere. Memorial tablets and marble busts are conspicuous by their absence, and the over-worked caduceus and other similar emblems which directly or indirectly remind one of sickness and suffering have given way to a simple but pleasing style of architectural treatment.

The second floor, which will be known as the Laura Franklin-Delano Foundation, will be used

FROM ROOF TO BASEMENT FIFTH AVENUE HOSPITAL CHALLENGES ATTENTION

A beautiful view of Central Park is seen from the roof of the hospital (center). Above are pictures of one of the loggias on the roof (left) and a corner of the roof itself; below are views of the rotunda and a patient's room.

The supervisor's office on the seventh floor commands a view of the elevator, the visitors' reception room and the service room.

exclusively for the care of children, and will be arranged in the form of large open rooms, together with a number of glass cubicles. The special arrangement of these rooms and cubicles with relation to the four distinct utility centers, insures elasticity of service and ready control. On this floor will also be found a school room for children, dental office, play rooms, dining rooms, as well as other facilities, and in addition there is a large open-air play roof which makes it unnecessary to take children to the main roof.

Surgical supply room, showing dressing trays ready for distribution.

The arrangement of the third floor is typical of that of the fourth and fifth floors also. The four wings containing the patients' rooms, radiate from a central rotunda, around which are located the supervisor's office, the service pantry, the visitors' reception room, two passenger elevators, and directly back of the last mentioned, two completely equipped treatment rooms. The central location of the supervisor's office enables that official to have a direct view of the above mentioned departments. She may observe any one alighting from an elevator, and commands a view of the visitors' reception room, as well as the service room on the opposite side. Adjoining the supervisor's office is a small service room where special treatments may be prepared, and directly back of this room will be found the rest room for special nurses.

There are fifty-four single rooms on this floor, each furnished with a toilet, lavatory and necessary equipment. The rooms are from 8½ to 9 feet wide by 16 feet long, and it is these rooms that will be set aside for those who cannot afford the higher-priced rooms of the seventh floor. The equipment of each room with the fixtures already mentioned, insures prompt bedside service. In attending to the ordinary wants of the patient the nurse will travel approximately four feet from the bedside of the patient to the small toilet room, above described. Should special articles be required, the nurse may communicate directly with her supervisor by automatic phone.

The sixth floor, or maternity department, provides accommodations for thirty-eight adults and forty-five babies. Here you will find three delivery rooms, two for general use and one especially equipped for the care of infected cases. The color scheme for delivery rooms is French gray throughout. Considerable attention was given to the old time problem of "noise" and through the use of glass doors, appropriately located, we have succeeded in isolating the labor rooms, delivery rooms and nurseries. In addition to this, the ceilings of the labor rooms and the nurseries have been made soundproof. The last mentioned feature has already proved its worth.

The rooms on the

Pupil nurses' dining room, showing facilities for cafeteria service.

seventh floor are not unlike the rooms on the third, fourth and fifth floors, except that they are somewhat larger and a number of them have private baths. The construction of some of these rooms is so arranged that they may be used en suite if necessary.

The eighth floor is devoted entirely to the highly developed scientific departments.

The operating rooms, seven in number, occupy the northeast wing. Here will be found the clinic operating room with an ampitheater of modest proportions, two private operating rooms, a special operating room for genito-urinary cases and a cystoscopic room nearby. There are also special operating rooms for the eye, ear, nose and throat departments as well as a plaster room for the orthopedic service. In the general operating rooms there is one surgeons' scrub-up sink and one sterilizing unit for each of two rooms, and it may be well also to add that each operating room is provided with a recessed wall cabinet for dressings and supplies. The color scheme for the operating pavilion is similar to that in the delivery rooms of the maternity department, French gray throughout. One of the unusual features in connection with the arrangement of the anesthetic rooms is the complete absence of anything that will suggest a surgical operation. White marble walls and tile floors are not in evidence. The rooms resemble small parlors and are furnished with curtains, wooden furniture, etc., the color scheme being a flat-finish buff. Special attention has been given to the ventilation of these rooms in order that the fumes of ether may be quickly removed.

The main kitchen is centrally located and with the diet kitchen provides the food service for the entire hospital.

The special diet kitchen. This kitchen and the main kitchen are centrally located and provide the food service for the entire hospital.

The general operating room.

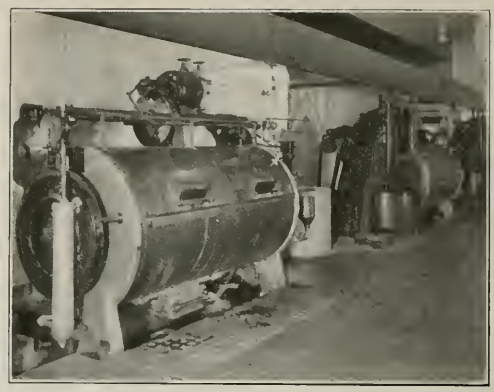
The pathological and bacteriological laboratories occupy the southwest wing. The equipment is modern in every respect and in keeping with the hospital. One of the special features of this department is dumb waiter service which transports all specimens directly from the several floors into the pathological department.

The department of gastro-enterology and x-ray occupies the entire southeast wing, and here will be found reception rooms, dressing rooms for patients, two exposure rooms, special examining rooms and fluroscopic rooms.

In the northwest wing are located the examination and special treatment rooms for the department of medicine. These rooms will be equipped with electro-cardiograph, baso-metabolism apparatus, polygraph, electric wall plates, and other apparatus. Every facility necessary for the proper examination of the patient will be found in this spacious section.

A reference library for all of the departments of this floor occupies a central location near the

Sub-basement, showing thoroughly insulated pipes and tanks.



View of the wash room—laundry department.

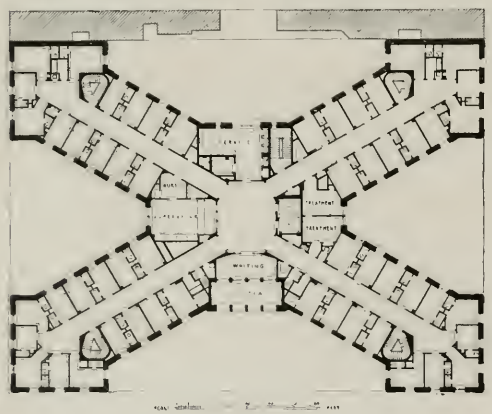
front of the building, adjoining the open loggia overlooking Central Park.

The staff room, where staff meetings are to be held, is located on this floor and is completely equipped with the appliances necessary for the proper demonstration of cases.

The ninth floor is being used temporarily for pupil nurses, but upon completion of a nurses' home will be devoted to the care of convalescent patients.

The tenth floor, or roof, provides, in addition to the four open-air roofs, a large solarium for use during the winter season. Ample provision has been made for tray service to the roof. If desired, patients may remain on the roof all day and receive treatment and nourishment without interruption.

The foregoing description deals in a general way with the outstanding features of the Fifth Avenue Hospital, and one will readily understand that the central idea of the entire plan is concentration. From the basement to the roof, this idea has been carried out and it is believed that as the details of the organization are perfected, the advantages of this centralization of control will become more apparent each day.



Typical plan of third, fourth and fifth floors.

BUFFALO SUPERINTENDENT EXTENDS INVITATION

The Board of Managers of the Hospitals and Dispensaries of Buffalo, N. Y., of which Dr. Walter S. Goodale is the superintendent, issues an invitation to the members of the American Hospital Association to stop off at Buffalo on their way to or from their annual meeting to visit the Buffalo City Hospital. Extensive additions are being made to this hospital and the Honorable City Council of Buffalo has just appropriated an additional $836,000 for the equipping and furnishing of the hospital. There will be a formal opening on October 1, 1922, when there will be thrown open to the public an institution costing $3,500,000 and having a capacity of 836 beds.

CALIFORNIANS HOLD ANNUAL MEETING

The second annual conference of the Hospitals of California, which is held under the auspices of the League for the Conservation of Public Health, will convene September 5-8 at the Maryland Hotel at Pasadena.

Some of the topics listed for papers and discussion at the various sessions include: general consideration of hospital problems; the physical hospital plant; owners, governing bodies and executives; clinical departments, including hospital and out-patient services; general utility departments, and hospital administration.

At the same time the Council of the Medical Society of California will meet at Pasadena.

OPENS SOCIAL SERVICE WARD

St. Mark's Hospital in New York has recently opened a free social service ward for women and children. Its purpose is to give careful and scientific study and treatment to cases involving venereal disease and allied problems in the personal and family relations. All social agencies, hospitals, dispensaries and physicians of the city are being urged to refer their patients to this ward.

THE A B C MOVEMENT FOR HOSPITALIZATION IN THE COUNTIES OF MISSOURI

By FRANK G. NIFONG, M.D., F.A.C.S., Columbia, Mo.

TO REPORT properly the modern rural hospital movement one must necessarily call attention to some of the problems to be solved in rendering medical service to the country people.

The writer has had the privilege of practicing medicine about an equal length of time in one of the larger cities and in a rural community. This has given him a dual point of view and a more correct appreciation of conditions to be met in both city and country. In considering the two, a contrast forcibly impressed upon him is the great handicap under which the country doctor renders medical service to country people, whether they be rich or poor. Our city folk are now supplied with the most modern hospital facilities for all classes, aided by group practice and apparently the ultimate in diagnostic facilities. In the country we have noble service but inadequate equipment and often poor facilities. We still have a few left of the old-time general practitioners. (God bless them!) These are the men who are giving more real service in proportion to their opportunities than all the other groups combined, and it is devoutly to be wished that they may be kept in service for a long time to come. The best thing that could come to our country people (and to most of our city folk too, for they come chiefly from the country) would be a new supply of these doctors of the old school, with their ideals and altruistic service, modified only by a better medical education and improved opportunities to make use of the latest and best diagnostic and therapeutic aids. Doctors who serve in the country should be provided with improved equipment and better facilities.

The Need for Country Hospitals

The need for hospital service in the country has further been impressed upon the writer because we have here in Columbia a small hospital administered by the University of Missouri. This hospital is open to the citizens of Boone County, and it is rather conservative to estimate that through its service twenty-five or thirty lives are saved in the county yearly in emergency surgical cases alone. The rich and poor alike have needed this service. It is as essential that the wealthy citizen, if his life is to be saved, receive immediate hospital service as it is for the pauper, and there is no time to send to the city for a surgeon in emergencies. In this way the hospital need here has been emphasized and it has made the way easier for the people to tax themselves for hospital purposes.

Audrain County General Hospital, Mexico, Mo.

We know that our country people, those who produce our food, are the very foundation of our society and of our national existence. Anything we may do to make life more tolerable and more pleasant in the country goes far toward solving a great national problem. It is useless to cry, "back to the farm." We must give the workers on farms

equal advantage with the people in cities. We must give them good schools, good roads, and equally good hospitals and medical service.

State Medicine and Socialistic Schemes

Tendencies toward "state medicine" and socialistic schemes are showing themselves, and even now a note of warning is sounded in our national and state medical organizations. Nothing could be more disastrous than that form of state medical service which attempts to give aid to the individual patient through the state hired doctor. The English "panel" game is abominable and would be worse if applied to our country.

But what are we to do? Modern scientific medicine is too intricate and too vast for either the country or the city doctor to compass it entirely. We must have team work. We must have our medical centers and our laboratories and all our work collaborated. Where may the country doctor get help, especially for his sick poor? The state must help him. It is state aid to the individual, isolated practitioner which must be furnished. The state should not attempt to treat its poor by paid agents; it should give aid to individual doctors with laboratory and like assistance. It is the state's business, and good business too, to care for all its derelicts, whether mental or physical. Our good State of Missouri has as her motto, "The welfare of the people is the supreme law." Welfare might reasonably be made synonymous with health, and the "health of the people" be made our supreme law. But the health of the people is not to be conserved by some abominable, socialistic scheme whereby medical service might be rendered by hired doctors apportioned to the poor of certain districts. The state must leave the medical man free to work unhampered. No scheme could more quickly destroy our most altruistic and noble profession than one which destroys all individuality, ambition and incentive to work. The state provides for the welfare of the people by giving us good health laws and good boards of health and by fostering medical education; she should still further assist by giving us a comprehensive system of hospitalization, with laboratory and diagnostic assistance for the country doctors.

Callaway County General Hospital, Fulton, Mo.

Duty of the State to Its Sick Poor

Not only should the state care for its mental sick in psychopathic hospitals but for all other derelicts in a state general hospital. By a comprehensive system of hospitalization, a state general hospital, articulating with county and community hospitals, might well care for the sick poor of the state, as the poor of our better and larger cities are cared for. These poor people of the country must have this care, for they are as worthy and as important a part of our population as the city poor. It is a matter of justice and right, and it is a matter of extreme importance if we wish to keep our country people on the farms to produce our foods. We should have a state general hospital to which any indigent individual of the state may be sent for rehabilitation. We should have a state hospital with which may be articulated the county general hospitals. By this means we may have a great, coordinated system of hospital service over the entire state. We may standardize these articulated hospitals to certain grades of efficiency for the privilege of articulation and of being accredited. The state hospital might well become the supreme court in medicine, and to this court the isolated country doctor might bring his difficult cases and receive

the utmost benefit both for himself and his patient. This, then, should be our objective: a state and county hospital system which would give our poor as well as our rich people in the country, hospital advantages equal to those in cities.

Country People Need Modern Hospital

We must have as good medical service in the country as in the cities. How may we get it? The modern hospital must be given to the people in the country; otherwise it is impossible.

No one factor in modern scientific medicine is of greater importance and value than hospital service. It is the greatest aid; and it is essential in giving scientific, medical service. If it is the duty of the state and county units to care for the sick by making it possible for the medical profession to render the best and most scientific service possible, it is their duty to build, equip and maintain modern hospitals.

The importance of hospitalization and the great need for country hospitals is becoming increasingly evident. Note the recent prominence and the accented importance of the small community hospital. The people and the profession are awakening both to the possibilities and to the need of such service. The service which this class of hospitals can perform is of equal value to that of the metropolitan hospitals and may ultimately be of as great volume. The time will come soon when communities and counties will support hospitals unquestioningly and will submit to taxation for their support as they do for schools and roads.

The Limitations of Small Hospitals

We have listened on occasion to discussions on hospital administration and on what is necessary in staff work and nursing before an institution is worthy the name of hospital. We have also heard the small hospital anathematized and condemned most indiscriminately. We are fully aware of the deficiencies of small institutions and of certain limitations which they must have. The fact that these institutions have limitations and deficiencies, and some of them abuses, and the additional fact that they are increasing rapidly in response to a real need, makes it all the more important that hospital administrators give thought to their organization and lend all the aid possible in standardizing them and bringing them up to the highest possible level of efficiency.

These, then, are some of the reasons for this communication, a preliminary report, it may be called, on this new county hospital project in Missouri. We are, of course, in the experimental stage, a laboratory experiment in hospitalizing it may be called. We hope to benefit other communities and countries by our failures as well as by our successes. We are pioneering.

Boone County Conditions

We have in Boone County a population of more than 30,000; Columbia, a town of about 12,000, has a student population during the season of about 5,000. We felt the need of hospital service for the rural population particularly; for, as explained before, the University of Missouri has only a small hospital serving the students and some of the citizens, and this situation simply accentuated our needs. How might we get a hospital? In 1916 we saw in THE MODERN HOSPITAL a notice of a county hospital law in Iowa and Indiana. We secured the Iowa statute and had it introduced, slightly modified, in our legislature, and it became our law in 1917. This law provides that any county may vote bonds and a tax for the erection and maintenance of a county hospital. A petition with 200 names subscribed, one-half in the county and the other half in the town in which the hospital is to be erected, is presented to the county court and the court calls an election. Our constitution makes it necessary that a two-thirds majority be obtained for the measure to carry. The first trustees are appointed by the court and afterwards elected at regular elections, two and three alternately. Trustees serve without

Boone County General Hospital, Columbia, Mo.

pay and are nonpartisan. The law gives the trustees absolute management, and they may make any rules they see fit to administer the institution. All legal practitioners of medicine may practice in the hospital, so long as they obey the rules laid down by the trustees. The trustees may exclude any patient or any physician for infraction of rules. A separate tuberculosis hospital may be built and administered by this board. The county court may apply five per cent of the revenue of the county for maintenance if it sees fit. A training school for nurses may be established. This, briefly, is the law.

Immediately after the war we felt more than ever our great need for such a hospital. The neighboring counties of Audrain and Callaway

Corner of lobby, Boone County Hospital.

The solarium at Boone County Hospital.

first voted and found they had not asked enough to erect what they needed. They immediately voted for more money and received it. Boone County came next and made the same mistake, for building prices were at the peak. We asked for $100,000, got our estimates, and found we needed more. We then asked for an additional $75,000 and received it, when we let contracts for our plant. The assessment now is one and one-fourth mill, or $1.25 per thousand, which, you will observe, is not heavy. We now have three beautiful hospitals in the three adjoining counties of Audrain, Boone and Callaway, and we are pleased to call this the A B C movement for county hospitalization. We are the pioneers in this state in this movement, and therefore regard it as an important experiment.

Now, as to our own Boone County Hospital. Our buildings were completed and the house was opened December 15, 1921. In the first five months of service we had received 275 patients. We employ all graduate nurses. We have a superior culinary service. We have an x-ray department doing daily service for house patients as well as for outside patients. We have a laboratory which does all the fundamental work, and this is supplemented by having the Wassermanns and the pathological sections done by the medical department of the University of Missouri. This hospital is by law an "open hospital," and all legal practitioners have entree.

Many dangers might be pointed out which might easily arise: petty politics and lack of vision, inefficiency in management, and such things. It is extremely important that boards of trustees be men of character and capacity. Our counties have been extremely fortunate in having men, appointed by our courts, of high class and character. It has been very gratifying to medical men to see the interest and enthusiasm displayed by this board of trustees. We are convinced that, with a little care, we may always have men on these boards who will serve their people as disinterestedly as would a most ethical doctor. The selection of a superintendent is a difficult problem, and it gave our trustees more concern than anything else. We need more women nurses trained to administer small hospitals. We were fortunate in securing a woman superintendent of unusual ability; one with the ideals and practical good sense that will go far to show the way and work out our problems in the most practical way. When we reflect that the superintendent of a hospital must deal with all kinds of doctors as well as with all classes of patients, we realize that he or she should be a master in diplomacy. If we add to this the management of a nursing staff of variable capacity, the employment of common help of all grades of efficiency, running what is at once a hotel of superior quality and a house, with all the technical service and appurtenances pertaining to a hospital added on, it can readily be seen that exceptional ability as well as remarkable stability are required.

A staff seemed to be a difficult problem in an open hospital. We realized that no hospital is

really worthy the name without a good working staff. How might we have such a staff? We have undertaken to solve that most important problem through the machinery of regular organized medicine. The Boone County Medical Society supplies the staff—a volunteer visiting staff. Individual members of the medical society have volunteered to the trustees to take over the various divisions of service, pledging themselves that they will care for all indigent patients or for all patients who may enter the hospital, and the hospital be paid for their service whether by individuals, churches, lodges or the county court. They also pledge themselves to serve in the out-patient department when that may be established.

We have regularly organized with a chief of staff, vice chairman, secretary, advisory committee, etc. We have a quarterly alternating service in internal medicine, general surgery, obstetrics, pediatrics, genito-urinary and skin, gynecology, x-ray and laboratory; consultants on pathology, physiology and x-ray. We have lectures on public health and preventive medicine and volunteer inspectors of public school children. The executive committee of the staff acts in an advisory capacity to the trustees and superintendent. The chief of staff is an ex-officio member. We hope to open our out-patient department very shortly in the several departments, and will thereby increase greatly our field of usefulness. Under this plan you will see that we are using regularly organized medical men as our working staff. We volunteer as a unit and exclude thereby irregular, inefficient service. We also assume the responsibility of giving the best service, and it is "up to" the County Medical Society to make good. Every member of the county society has equal opportunity; there is no discrimination. It promises to become a matter of the survival of the fittest, or at least of the "workingest." So far the arrangement has worked most beautifully, and all are entering into the work with great enthusiasm and vim. A higher standard is steadily being set, and improvement is noticed all along the line, even now. The more intimate association has increased good fellowship and understanding as well as mutual respect and good will. It looks like the objective through which good team work may be accomplished. We have staff meetings each month in which we review our cases and the work of the hospital. Anything for the good of the service is discussed. The monthly report is furnished from the office by the superintendent. Each death is particularly inquired into, and criticisms are both mercilessly and cordially made. We have a large room set aside on the fourth floor by our trustees for staff meetings and for the meetings of the county society. Here also may be held other meetings having a health service side to them, such as mothers' clubs, inspecting and teaching school children and similar work. We are having installed a lantern and a moving picture machine which will help in our efforts to educate the children as well as ourselves.

Patient's room at Boone County Hospital.

Boone County General Hospital kitchen.

We desire to make the Boone County Hospital function also as an educational force. We hope it may be a center from which will radiate every kind of activity which will promote health and well being. We feel that not the least important part to play is through an educational program. All our school children from the rural schools should be inspected here, and we hope to begin this inspection soon. While we have the children there we hope to teach them some of the elements of medicine and rules of good health. This is both easy and practical now, especially with the aid of visual education.

This, briefly, is some of our program and some of our problems. In time we contemplate having a nurses' training school, or perhaps a school for training nurses' assistants. At present we are using only graduate nurses. Our rates are exceed-

ingly low, being from $2.50 per diem for the county patient to $6 for the choicest room and bath, such as one would have to pay $10 or $12 for in a choice metropolitan hospital. Most likely these rates may have to be revised upward, especially if the county cases are very numerous. The revenue from the mill tax amounts this year to nearly $50,000. About $16,000 must be used for sinking fund and interest. Thirty thousand dollars will be available for maintenance and building. It is to be hoped that this, added to the income from pay patients, will make it possible to "break even" at the end of the year. Our law makes provision for the acceptance of gifts; no doubt they will be needed; they will certainly always be welcome. It is the desire to give not only the best service possible, but to render it to all classes of people.

We are also thinking of the future and of our increasing population. Our grounds are close in town and are four acres in extent, allowing plenty of room for expansion. Our buildings are planned for expansion, so that when additional wings are builded we may add seventy-five and again seventy-five beds, and ultimately have a 200-bed hospital. Also, we have room for a pavilion for infectious diseases, something much needed in a college town. An old residence on the property has been made into a nurses' home until such time as a modern one may be built.

In building and equipment up to this time, we have expended something like $225,000.

Hospitals are somewhat costly; but the time has come when we must have them, even in the country. No investment pays bigger returns in health, welfare and happiness.

ELIMINATING FEAR FROM THE MIND OF THE SURGICAL PATIENT

The hospital doorman's smile and the telephone girl's voice, as well as the use of practical psychology by anesthetist, surgeon and nurse, have their place in eliminating the element of fear from the mind of the surgical patient, says Dr. Donald Guthrie of Sayre, Pa., in an article in a recent issue of the *New York State Journal of Medicine*. The personnel of the hospital, he declares, should be chosen with great care on this account. Little touches of human kindness will do much to rob hospitals of the cold institutional atmosphere which frightens many diffident patients and interferes with many satisfactory recoveries, he believes, and the surgeon and his co-workers must have a contagious optimism.

For this reason hotels and hospitals frequently and rightly employ fat doormen, for the fat man is usually good natured and cordial and slow to anger. A rasping, impatient voice of a telephone operator in the office of admission or the cold, business-like filling out of a questionnaire by some frigid clerk oftentimes gives the new arrival in the hospital the wrong impression of the spirit of the institution. A little display of cordiality and friendly feeling, says Dr. Guthrie, is by no means lost.

When the patient is admitted to the ward, the New York state doctor says, he should be waited upon promptly by attendants and nurses who have been specially trained. The patient must be spared seeing, smelling and hearing things which are objectionable. He should be admitted to a ward filled only with convalescent patients, who are happy and free from pain. Operative cases should never be moved into a big ward until they are out of pain, no painful dressing should be done on the ward, nor should a death be allowed to take place there. The mental peace of the new arrival should have this consideration, he asserts, for fear injected into the patient's mind at the beginning of his hospital stay is not conducive to a comfortable and quick convalescence.

Nor is it right to have operations delayed for an unnecessarily long time if there is nothing about the patient's case that justifies such a delay, Dr. Guthrie states. The surgeon or his associate should visit the patient the night before the operation and at this time assure him that his malady is curable, indicate the operation and set his mind at rest on his physical fitness for it. If possible he should be allowed to talk with convalescent patients who have had similar operations and have had quick and comfortable recoveries. The spirit to win, says Dr. Guthrie, is half the battle and the patient who feels, or can be made to feel, certain that he is going to come through a surgical ordeal usually does get well. On the other hand the patient who is convinced he is going to die before his operation, who fears that everything is being misrepresented to him, generally does die or have the most stormy sort of convalescence.

The night before operation must be spent in sound, restful sleep. Patients should not be dehydrated by preoperative purges and their rest thus broken, in Dr. Guthrie's opinion. Most surgeons have discarded the castor oil or saline purge, and now rely upon the mildest of laxatives or enemas. Operations should be scheduled as early as possible in the morning so as to spare the patient the dreaded wait, the annoying thirst and the prostration from hunger. If for any reason, the operation cannot be performed until late in the morning or in the afternoon, he thinks the patient should be given warm fluids, such as tea, coffee or broths.

Two parts anesthetic and eight parts suggestion is the best mixture for the patient at the beginning of anesthesia, says Dr. Guthrie. The anesthetist must be a skilled psychologist and have a personality which can readily apply different kinds of suggestion to different individuals. He is the most valuable member of the operating team if properly trained and possessed of the right personality, the physician believes.

"All surgical patients must be examined by the surgeon or his associate before they are ready to leave the hospital," says Dr. Guthrie in conclusion. "At this time the patient's disease or operation should be explained to him in detail, all final instructions for his after-care carefully given him, besides telling him that his home physician will be written about his case. This gives him a sense of security at home, and the request that he write back a report of himself from time to time is met with delight, for he feels that the interest shown in him will not come to an end when he leaves."

ASSISTANT DIRECTOR AT MT. SINAI HOSPITAL

Dr. Joseph Turner, formerly superintendent, Eagleville Sanatorium, Eagleville, Pa., has been made second assistant director of Mt. Sinai Hospital, New York.

BRINGING CLIMATE TO THE PATIENT

By W. DWIGHT PIERCE, PhD., Managing Director, Biological Department, The Mineral, Metal and By-Products Company, San Mateo, Cal.

ONE of the first steps made in the science of sanitation was in the direction of air-conditioning when the demand for pure fresh air became insistent. Through other incentives entirely there has arisen a science of air-conditioning which can give much of value to sanitary and medical science, and we will do well to consider what has been accomplished, what underlies the whole science, and how especially it can be applied in the field of health.

In general, we have known that air overcharged with carbon dioxide is unhealthy, and rules have been laid down specifying the maximum volume of carbon dioxide permissible in public buildings. But the student of air-conditioning now assures us that the capacity of the air to absorb carbon dioxide or any other gas and its danger to human health depends entirely upon the varying factors of temperature, atmospheric pressure and relative humidity. This fact was especially brought out in the report of the Departmental Committee on Humidity and Ventilation in Cotton Weaving Sheds (Cd. 4484, London, 1909). This report was necessitated by a desire to obtain satisfactory weaving conditions without too greatly affecting the health of the laborer, but its finding did not result in laying down any definite principles upon which a real science of air-conditioning could be built.

To the textile industry probably we owe the first serious efforts to control humidity in industrial establishments, as it was found that without sufficient atmospheric moisture static electricity interfered with the processes, the fibers were more liable to break and the fabric was not uniform. In fact, two very responsible engineering corporations have built up a large business through the development of systems of air-conditioning, including ventilation, air-washing, humidifying, dehumidifying, warming, cooling and drying. These systems are the gradual outgrowth of the demands of the textile industry and later other industries of many kinds to attain more suitable air conditions for their particular processes. These corporations have by individual plant studies worked out to the satisfaction of their clientele apparatus whereby the various plants have been able to improve the quality of their product in appearance or strength, or in some other manner, and much credit is due to them for their pioneer work.

But the field of air-conditioning is broader and more vital than accepted by even these pioneers. It opens up visions of greater industrial health, greater personal efficiency and possibly a new principle of hospitalization. It is in the effort to bring these new ideas to the medical and sanitary professions that the present article was prepared.

Based on Principles of Sanitation

Expressing the basic principles in terms of the sanitarian and practitioner, we may set down a number of theorems which appear to be fairly well grounded at the present time.

(1) The normal physiological functioning of the body requires fresh air, or air not overcharged with carbon dioxide, or any other injurious gas.

(2) Modern industrial practice makes it possible to secure fresh air, or air made fresh by washing, and to maintain it at whatever combination of conditions may be specified by thermostatic automatic control.

(3) The quantity of carbon dioxide which may be held in suspension in the air with safety to the worker depends upon the factors of temperature, relative humidity and atmospheric pressure.

(4) The reactions of temperature upon living organisms can only be correctly thought of in terms of humid-temperature.

(5) At a given temperature the capacity of the air to absorb moisture depends upon atmospheric pressure.

(6) For every living creature, plant or animal, no matter how low in the scale of development it may be, there is a zone of humid-temperatures in which the life functions of metabolism, assimilation, transpiration, growth and reproduction are at their greatest efficiency. This applies to every cell and organ of every creature and to every function of the organism. By greatest efficiency we do not necessarily mean capability to do the greatest amount of work, but rather the capability to do the greatest amount of accurate, dependable work with the least exhaustion, wear and tear. This zone of temperature and relative humidity is what we used to call the optimum, but was renamed the practicotatum by the writer. The practicotatum for man is a zone, more or less elliptical in form if charted on paper, having approximately as its ultimate boundaries 32 and 55 per cent humidity and 55° and 70° F. temperature. This zone was denominated by Rosenau as the comfort zone, for within it we are the least conscious of the existence of air conditions and

feel the greatest sensation of personal comfort.

(7) The factory, school, hospital, office building, church or auditorium equipped with modern air-conditioning apparatus that will maintain throughout the year a fixed condition within this human practicotatum will, needless to say, maintain the conditions most favorable to health, happiness, contentment and human efficiency. With proper measures for reduction of gases and dusts such conditions are almost ideal. It is no longer an imaginary condition, but an actual reality, and so accurate that by thermostatic and hygrostatic control temperature is held within two degrees and humidity within four per cent by both the leading systems of air-conditioning.

(8) Surrounding the practicotatum is a more or less large thermopractic zone, which in the case of man we may call the zone of practical working conditions, and for other living creatures we may call the zone of effective humid-temperatures. Broadly speaking no man should be expected to work, except for very short periods under factory conditions, at humid-temperatures outside of this zone, which may be roughly described as bounded by 36° and 90°F. and 2 per cent and 85 per cent humidity, with a diagonal axis running from 43° F. and 100 per cent humidity to 78°F. and 0 per cent humidity, elliptical in form with the short axis perpendicular at 63°F. and 43.5 per cent humidity. The curve of the ellipse is tangent upon but does not cross the line of the wet bulb of 70° at 30 inches pressure.

(9) Hospital patients should be kept by all means within this zone, for it is the zone of bodily activity, and how can we expect the healing processes to take place when the air conditions inhibit them? The nearer the patient can be kept to the practicotatum the better. Of course in this connection we must remember that the disease organism also has its practicotatum and our patient must be held under thermopractic conditions least effective for the disease and most effective for the recuperative processes in the patient's own body.

"Climate Has Been Conquered"

(10) Any condition of weather can be brought into any factory or hospital. Geography and climate have been conquered. If you want to do something which has always in the past been associated with a certain place or climate, you can now do it at home by installing artificial weather. There is no reason for sending a patient to a distant climate, which may be exhausting and enervating and far out of the bounds of effective conditions, when in the hospital in his home town near friends and the source of funds, he can be kept in a cheerier mood at the most favorable conditions for the curing of his malady.

(11) Surrounding the zone of practical working conditions are subzones of debilitation and discomfort, of sluggishness, of pain and intense suffering (either from cold, heat, dryness, or moisture). Work is often done under these conditions, but it cannot be satisfactorily done, and the health of the laborer is soon impaired. Any condition which causes a feeling of chill, a benumbing, a thirsty or parched condition, excessive perspiration, stifling, depressing fatigue, frequent need of rest, quickened or sluggish pulse or fever is dangerous to health, and lies within the boundaries of these subzones of debilitation, sluggishness and pain. Under no circumstances should hospital patients be kept under such air conditions.

The Anesthetic Zone

(12) Surrounding these subzones is the anesthetic zone or zone of unconsciousness, comprising all those conditions which induce sleep and unconsciousness preceding death. In the lower animals true anesthesia is displayed by the phenomena known as hibernation and aestivation which the writer has shown are one and the same phenomenon. For instance in dry countries, an insect may be in the anesthetic zone throughout summer, fall, winter, and in fact through several years with extremes of hot and cold weather, and will only awaken when the necessary humidity brings the air conditions within the zone of effective humid-temperatures. With man the anesthetic zone is very dangerous but we see it in people who fall asleep in the cold (rhiganesthesia), or who collapse from thermoplegia or heat stroke, and are while unconscious in a state of thermanesthesia. The human death zone (olethric zone) is very close to the anesthetic zone and its position depends largely upon the individual's physical condition.

(13) A temperature which is thermopractic at one humidity (that is 90°F. at 35 per cent humidity, may be thermonochelic causing sluggishness —at another humidity (90°F. at 65 per cent humidity); thermalgesic causing pain and fever at another humidity, (90°F. at 80 per cent humidity), and thermanesthetic, thermoplegic or thermolethric at a still different humidity (witness strokes and death at 90°F. and 100 per cent humidity).

(14) Although 90°F. and 100 per cent humidity brings about stroke and death, such a condition at 5 per cent humidity is not likely below 115°F.

(15) Although 70 per cent humidity is regarded as the best for weaving we must not think

that any temperature can be withstood at this humidity, for stroke and death may occur at 70 per cent above 105°; at 100° only cautious work is possible, because of rapid rise in body temperature; at 90° hard work is impossible; and in fact operatives should not be required to work above 82°; at 79° one feels discomfort and perspiration; but below 75° there is little or no discomfort in ordinary clothing; at 65° to 70° the best weaving is done in England; at 60° English weavers are satisfied; at 50° to 57° best work is done in New England; below 37° a sense of chilliness is experienced; below 28° one is sluggish; below 22° pain and frost bite are experienced; and below 10° there is danger of freezing to death unless very active, warmly dressed, and well nourished.

There is no doubt but that any industry adopting this modern theory of air-conditioning and installing an appropriate system therefor will greatly increase the efficiency and health of its workers, as well as better the quality of its products. Bread made by the new system of air-conditioning is superior in quality, and the same may be said of macaroni, candies, chemicals and drugs, rubber, and chewing gum, and multitudes of other products. Needless to say foods made under sanitary air conditions will be superior also from the sanitary standpoint.

Some possibilities in controlling air conditions which have scarcely been dreamed of by the hospital executive are outlined by Dr. Pierce in the accompanying article. Just how practical they may be the near future will undoubtedly tell. In certain industries, the application of these principles have made working conditions not only tolerable but even pleasant. The author of this manuscript sees them as revolutionizing hospital air-conditioning practice.

"Any condition of weather can be brought into the hospital," says Dr. Pierce. "Geography and climate have been conquered. If you want to do something which has always in the past been associated with a certain place or climate, you can now do it at home by installing artificial weather. There is no reason for sending a patient to a distant climate which may be exhausting and enervating and far out of the bounds of effective conditions, when in the hospital in his home town near friends and the source of funds he can be kept in a cheerier mood at the most favorable conditions for curing his malady.

"Any condition which causes a feeling of chill, a benumbing, a thirsty or parched condition, excessive perspiration, stifling, depressing fatigue, frequent need of rest, quickened or sluggish pulse or fever is dangerous to the health and lies within the boundaries of the subzones of debilitation, sluggishness and pain. Under no circumstances should hospital patients be kept under such air conditions."

It is not the province of this article to speak of the relative merits of the commercial systems in use, but the purchaser can expect satisfaction if he receives a guarantee that the system when installed will meet his specifications. He should specify an air-conditioning system that will enable him to control both humidity and temperature automatically in any room or throughout the plant at any fixed combination he shall desire; that the system shall be so flexible that the conditions in any room may be set at will by adjusting the automatic controls; that he may maintain different air conditions in different departments at the same time. In the rainy season the humidity is too high outside and the dehumidifier must rectify this in the plant. In the dry season the humidifier will carry the burden. In the cold weather the heating system, and in the hot weather the refrigerating system will function. In other words the true air-conditioning system has at least four functions — heating, cooling, drying, moistening and to these may be added air-washing and ventilating.

Just what combinations of temperature and humidity are necessary in any department to obtain the best quality and greatest quantity of this quality of product, with the greatest efficiency of machinery and at the least strain upon the physique of the laborer, is a question which must be determined by independent investigation in each department of a plant. In the human factor alone we must consider the racial reactions of the employes, the previous environment, the health and the clothing of the individuals. Just as by psychological tests we ascertain the relative fitness of applicants for particular tasks, by thermo-practice tests we must ascertain under what conditions the acceptable candidates are most fit and must endeavor to place them at their tasks under such conditions as to derive the greatest amount of efficiency from them.

Finally, without in any way desiring to express an affirmative opinion for or against any present-day system of hospital practice, the writer desires to set to thinking upon certain definite points those who are in better position to know.

(1) Presuming that fresh air is desirable, especially for patients with bronchial and lung diseases, is it true that any kind of fresh air is equally efficient? Arguing merely from personal behavior, the writer feels that raw cold air, supercharged with moisture, and hot stifling air, similarly charged, and intensely hot still dry air may be so depressing that the tissues have no chance to mend. Would not fresh vitalized air of moderate temperature and low humidity be the most desirable in the case of such diseases?

(2) Is it not possible that in fever cases a rapid change of air to give fresh oxygen and remove fever affluvia, maintained at a moderate moist temperature would give better results than uncontrolled air? Or at least, is it not possible that by controlling the air you could find conditions superior to the average uncontrolled hospital conditions?

(3) Would not dehumidification be of great aid in moist weather in the treatment of rheumatic and asthmatic patients?

(4) Is it possible that in diseases with alternating chill and fever the patient's condition might be ameliorated by a control in the opposite direction of the room conditions?

(5) In dealing with diseases characteristic of winter time would not fresh air conditions of summer time be of tremendous aid in hastening control of the diseases?

(6) Does not a patient recuperate faster when the air conditions are most pleasant?

(7) Would the obnoxious hospital disinfectant gases be as necessary if the air was constantly being changed and fresh washed air of suitable temperature replacing it? Would not the absence of these odors be beneficial in the cure of many patients with hypersusceptibility of gases?

LEAGUE TO CONDUCT EPIDEMIOLOGICAL INTELLIGENCE SERVICE

The International Health Board of the Rockefeller Foundation has entered into a cooperative arrangement with the Health Organization of the League of Nations whereby the board will provide a sum not to exceed $32,840 a year for a period of five years for the purpose of maintaining an international epidemiological intelligence service. The board will also provde a sum not to exceed $60,080 a year for three years to put into effect a scheme for the international exchange of public health personnel to be conducted under the auspices of the Health Organization of the League.

The Health Organization of the League of Nations was created in September, 1921. Its principal function at present is to conduct an international epidemiological information service and in general to promote international cooperation in the control of epidemic diseases. Incidentally it will advise the League in matters affecting health and cooperate with the International Labor Organization in promoting industrial hygiene.

Since its establishment the intelligence service has kept all governments informed as to the status of epidemics of typhus, intermittent fever and cholera, which have been sweeping westward from the famine-stricken regions of Russia. Negotiations among European governments looking to the adoption of sanitary conventions for the control of epidemic diseases have been initiated by the Health Organization and much progress already made. It has also undertaken to promote the international standardization of vaccines and serums.

For the first time in the history of the world there is an agency for taking steps to control epidemics before they get out of hand. The intelligence service of the League of Nations is of vital importance to the people of all countries. It is expected that by the end of the five-year period for which funds have been provided by the International Health Board the epidemiological intelligence service will have become so efficient and valuable that the various national governments will regard it as indispensable and provide funds for its further maintenance.

The exchange of public health personnel is expected to reinforce the other activities of the Health Organization by promoting mutual acquaintance, understanding and good-will on which effective international cooperation must be based. Interchange of health officials will be arranged not only for observation but for definite periods of service which will result in actual exchange of experience. The proposed system of exchanges will be put into effect first in Europe and may be extended as opportunity offers to other countries throughout the world.

DR. BIGELOW NAMED DIRECTOR OF CORNELL CLINIC

Dr. George H. Bigelow has assumed the position of director of the Cornell Clinic, the teaching clinic of Cornell University Medical College. Mr. C. F. Neergaard, who has been in charge of the clinic during the period of its reorganization from the old type of dispensary to a pay clinic, is now returning to business activities, although he will continue his general interest in the Cornell Clinic and in other hospital and dispensary affairs in New York.

Dr. Bigelow is a graduate of Harvard College and of the Harvard medical school; he served an internship in the Massachusetts General Hospital, was in the medical corps of the army during the war in this country and abroad, served as acting state epidemiologist of the Massachusetts state department of health, and was a member of the staff of the department of preventive medicine and hygiene of the Harvard medical school. During the past year, he has organized the department of industrial health of Antioch College, Ohio.

SUPERINTENDENT SHOULD BE IN COMMAND

A private hospital had for its chief surgeon a man that would often countermand many of the teachings of the superintendent of nurses with the result that the poor nurses did not know which teaching method to follow. On account of this situation the superintendent, who was very capable and efficient, left the institution. The same condition continued until the hospital had to be closed.

McLAUGHLIN HALL—A MEMORIAL TO NURSES

By STEWART HAMILTON, M.D., Superintendent, Harper Hospital, Detroit, Mich.

McLAUGHLIN Hall, which is said to be the most beautiful and complete nurses' home in the country, was given to Harper Hospital by Detroit's public spirited and philanthropic mayor, James Couzens, who is a member of the board of trustees of the hospital. The home is a memorial to the nurses of the Farrand Training School who served during the World War.

Sod was turned for the building March 9, 1921 by Miss Emily A. McLaughlin, principal of the Farrand Training School, who was chief nurse of Base Hospital No. 17 in France. Within less than a year from that date it was ready for occupancy, The formal opening was on May 10 which is the occasion of the reception given each year to the graduating class by the board of trustees of Harper Hospital. It was informally opened to the public May 12, National Hospital Day.

The building is located on a large plot of ground south of the hospital, with which it is connected by a tunnel. It is an imposing structure six stories high and it is so built that another story may be added. It has a capacity for 285 nurses. The architecture is of Italian Renaissance type. The outside is of brick, trimmed with limestone. It is dignified in design and its simplicity is relieved and given added color by several wrought iron balconies, as well as by pattern brick work in the frieze-like top story.

The building is in the shape of an inverted U surrounding a seventy-five foot court and has a frontage of 145 feet and a depth of 116 feet. It is entirely fireproof, its construction being of concrete, steel and brick.

Floors are all concrete; the halls, battleship linoleum, and bathrooms are of terrazzo finish. There are two stairways in the rear of each wing and one automatic elevator. The stairways are designed as fire escapes and are of concrete and steel with treads of terrazzo finish. They are separated from the halls on each floor by steel doors framing wire glass.

The exterior of the home is enclosed by a balustrade on the open side of the court which one reaches by a short flight of steps. The porch is Italian loggia in design and presents an attractive entrance. In the rear of the building running the entire length of the living room is a wide screened porch from which one looks down upon

McLaughlin Hall is one of the nation's most beautiful nurses' residences.

sunken gardens with walks of broken flagstones; farther on are the nurses' tennis courts rarely empty.

In another year landscape gardening will have added the softening touch of plant and shrub. The sunken gardens are of formal design to correspond with the architecture of the building and are enclosed in evergreens which are to be used as a ground cover in the form of a hedge. The same plan will be used for the front of the building.

This beautiful landscape gardening is a gift from the firm of Travis Brothers, one of the best

known landscape gardening companies in Michigan. The trees and shrubs are the gift of Greening Brothers from their excellent nurseries at Monroe, Mich.

Reception Hall Richly Furnished

Upon entering the first floor of the building from the front, one is admitted to a reception hall twenty-five feet square with a floor of large square tiles alternating gray and white. The character of the decoration is known as "Adam." All openings from this room are arched French doors and arched windows; the central openings to right and left are mirrors. The walls are in several shades of soft gray stippled over one another. The wood work is ivory and the ceiling is in low plaster relief decoration.

This room is furnished in walnut, with paneled walls. Small tables and chairs upholstered in blue are disposed around the room. Two large settees upholstered in rose are placed in front of the mirrored central openings. The carpet is of soft taupe and covers the floors of other rooms opening off the reception hall. An electrolier of brass in antique design hangs from the center of the ceiling and wall clusters with crystal trimmings from side walls.

The library opening off the living room carries the same color scheme and the same style of furniture with the addition of built-in bookcases on either side of the connecting doorway. The most attractive feature of the room is the antique ornamental plaster design of the slightly arched ceiling. A beautiful French mirror in a gold frame hangs in charming relief against the dark walnut finish of the walls.

At the right of the reception hall is a small reception room, beautiful in soft grays and ivory tints, and furnished with varying shades of green harmonizing with the colorings in the adjoining rooms. Silver electroliers and wall clusters complete its decoration. The unity of the color scheme is preserved by the taupe carpet, the soft pongee curtains and the rich chintz drapes throughout the four rooms dedicated to the social pleasure of the pupil nurses.

A business office for the desk of the house mother, containing telephone switchboard, mail boxes and electric light switches, opens off the main reception hall. There are buzzers in every bedroom by which the telephone operator calls its occupant to the telephones which are on every stair landing in the building.

The south wing contains a large beautifully furnished living room for the exclusive use of the supervisors of the hospital. It is furnished in dark wicker; upholstering and draperies are in fuchsia shades. At Christmas time the training school presented the faculty and supervisors with a silver tea and coffee percolator with creamer and sugar bowl for use in this room.

One reaches the living room which is directly beyond the reception hall through three sets of French doors. This beautiful room is forty feet long and 20 feet wide and opens upon a wide porch running its entire length by means of five French windows. At one end of the room is a large fireplace in which repose a pair of ancient andirons, the gift of Mrs. Barbara H. Bartlett, professor of public health nursing at the University of Michigan. At the opposite end of the room, a large double door leads to the library. Both the living room and the library are English in their decorative scheme, having a pilaster and wide panel treatment in gum wood, walnut finish, from floor to ceiling. The ceiling has a border of ornamental plaster in keeping with the panelling of the room. The fireplace and baseboards are finished in green Verde antique marble.

Bronze electroliers with wall clusters to match them, three floor lamps and two reading lamps of different designs complete the lighting which radiates through soft orange and tan shades.

Two long walnut tables for the living room and one for the library, with numerous chairs of walnut upholstered in blue and in various tapestry designs, are arranged so as to give the effect of several smaller rooms. Two lounges upholstered in blue and another in harmonious tapestry design complete the demand for comfort. The bright rich tones of the chintz in the curtains are carried over into the room in bits of bright pottery. In one end of the room there is a spacious walnut desk and in the other a Steinway baby grand piano, the Christmas gift of the Harper Hospital staff physicians to the training school.

The Principal's Quarters

The suite of rooms provided for the principal of the training school leaves nothing to be desired from the standpoint of beauty and comfort. One enters both the bedroom and the sitting room from the main hall. The rooms have a connecting hallway on one side of which is the bathroom and on the other built-in cupboards. An immense closet opens off the bedroom.

The bedroom is furnished in the lighter shades of walnut of colonial design and has a four poster bed with an old fashioned high boy, and a low dressing table and a rocker of the same design. Another chair and a plain screen with coverings of blue shot with copper lighten the effect. Copper-colored hangings tinged with blue drape the windows. The dominating color notes

The imposing entrance to McLaughlin Hall is Italian loggia in design.

of the room, including walls and woodwork, are all shades of the sepia family relieved by blues and copper.

In the sitting room the necessary contrast is found in the black wrought iron andirons of the fireplace and the candelabra of the mantle piece. A walnut bookcase occupies an inset in the wall next the fireplace and across from it is a low desk of rare design. A small settee and the window drapes are of Indian print. A tea wagon and a gateleg table as well as a small table, a floor lamp and two upholstered chairs complete the furniture. Some rare bits of pottery and pictures and a marble bust of Joan de Arc brought from France with the return of Base Hospital Unit 17 give to this exquisite room its final touch of individuality.

The remainder of the south wing contains eleven bedrooms for graduate nurses employed in the hospital in such positions as the admitting office, social service and out-patient departments, and for their use there are two showers, two tubs and eight wash basins as well as a kitchenette. A room with private bath is for the use of the house mother.

School Rooms and Laboratory

The entire north wing of the first floor is given over to the educational interests of the training school and emphasizes strongly the thought that has taken root in the minds of advanced hospital officials today, namely: that training schools for nurses are schools of nursing and need proper school equipment.

One large demonstration and lecture room seats sixty-five pupils and has room for six beds, one of which is continuously occupied by the famous Chase doll. It is a workroom and has closets and cabinets which contain the necessary articles for the successful demonstration of practical nursing procedure. It also contains a stationary washstand with hot and cold water, an ample blackboard and student chairs with wide arms for convenience in writing class and lecture notes. In place of the old gas plates upon which we have for years heated the water for demonstrations in the giving of fomentations there is provided an electric plate which may be attached to various plugs in different parts of the room.

A smaller classroom is equipped with special conveniences for the teaching of anatomy. It seats thirty persons comfortably and contains skeletons, models and anatomical charts. Still another classroom seats forty students and is used for a study room, classroom or examination room as needed.

A laboratory in which there is arrangement for fourteen Bunsen burners, any number of microscope lamps and sinks, large and small, furnishes the needed arrangement for teaching solutions in materia medica, microscopic work in bacteriology and test tube demonstrations in the examination of urine.

One of the most gratifying features of these classrooms is the overhead duplex-o-lite lighting which is uniform throughout the room and casts no shadows. Two of the classrooms contain stationary wash stands, desks for the instructors and all of them have the necessary blackboards.

Connected with the teaching wing is a lavatory

containing three wash basins and three toilets. In order to preserve the decorative scheme of the first floor, all doors leading to the classrooms are of French design. These are well as the windows have draperies of silk pongee; the walls are putty color, and the concrete floors are painted soft browns.

There are two full-time instructors and each has an office. Each office contains the necessary files, bookcases, typewriter and chairs. The furniture is dark oak; the floors are carpeted to harmonize with the walls and the drapes are of silk pongee.

Views of main reception hall (above) and living room.

A reference room with a capacity for one thousand volumes completes the plan of the educational wing of the home. This room is furnished with a library table, a dictionary and six straight chairs.

The auditorium and gymnasium are in the basement and thrown together will seat 350 persons. The auditorium has an outside entrance directly upon the sunken gardens. It contains a rolling stage which may be placed wherever desired and may also disappear altogether through an opening in the baseboard. There is a piano and 350 folding chairs. This room is for the use of the student nurses' entertainment at any time of day. It lends itself equally to dancing or a minstrel show as well as to dignified lecture and religious service. The Alumnae Association of the Farrand Training School has the free use of the room for meetings and for social functions, such as banquets, receptions and lectures. There are cloakrooms, a kitchen and serving room which furnish every convenience for entertainment.

Laundry tubs have been provided for the use of the student nurses. A unique device in connection with the electric irons is the red light which burns like a bright button on the wall opposite the one using the iron and remains as long as the electricity is turned on. Linen and sewing rooms for the use of the student nurses together with large trunk and storage rooms as well as lavatories and rest rooms for the maids complete the basement.

Another view of living room (above) and a nurse's bedroom.

The floors above the first all are exact duplicates of one another with the exception of the second which contains an infirmary for sick nurses. This may be entirely shut off from the

other part of the floor and contains a kitchenette for complete tray service as well as its own bath and lavatory.

Each floor contains twenty-eight single and eleven double rooms. The single rooms occupy the wings and the double rooms run across the rear of the house. The northeast and southeast corners have suites of two large rooms with a connecting bath for use of two supervisors.

The general finish of all walls is either putty color or a very soft grey with woodwork stained walnut. Windows of all bedrooms are forty-six inches wide including the casings. All rooms have a duplex-o-lite overhead light and a base-board plug for reading lamp. A plate rail runs around each room and obviates the necessity of using tacks and nails in the wall.

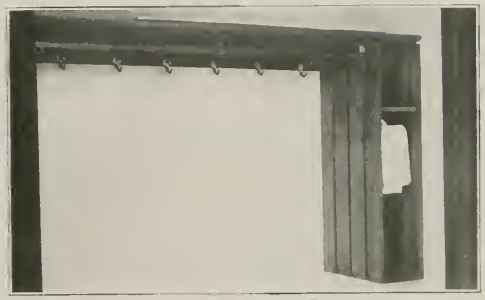
Two telephones and a kitchenette assist in making life comfortable for the occupants of each floor. The bathrooms and lavatories are in each wing, and for the entire floor there are four baths, four showers, two dental bowls and sixteen wash-bowls (exclusive of those which are in each of the double rooms.)

The Nurses' Sleeping Quarters

The double rooms each have two closets, two beds, a desk table and desk chair, and two rockers as well as two large rugs of mixed colors.

All the single rooms have a built-in wardrobe with a towel and tooth brush holder designed by Miss McLaughlin, of which there is an accompanying illustration. There is a desk table, desk chair, a windsor rocker and metal beds finished in cream or mahogany. Each room is given contrast by its deep cream-colored chairs trimmed in dark browns and blues and its mahogany bed, desk and bureau. Where the bed is cream in color the rest of the furniture is mahogany finish. Large rugs in grays, browns or taupes cover the floor. The window curtains are of marquisette, the overdrapes express the choice of the occupant and represent a riot of color.

Each supervisor's room contains a four poster mahogany bed with box springs. There is a bureau of colonial design to match, a desk table with desk chair, a windsor rocker, an upholstered wicker chair and a small bedside table. The floors are almost entirely covered by one large rug in neutral colors of browns, taupes or grays. The hangings were chosen by the supervisors from a number of samples furnished by the hospital, and the color plan of each room is their choice. Walls, woodwork and lighting are the same as in the pupil nurses' rooms. Each supervisor's room has two windows and large built-in wardrobe closets.



The wardrobe closet, showing buzzer, and towel and tooth-brush rack devised by Miss McLaughlin.

Aside from the arrangements for the principal and the floor supervisors as described, the assistant principal has a suite of two rooms and a bath and the senior instructor has the same.

From the moment the sod was turned for McLaughlin Hall an intense interest, almost personal, has been manifested by the architect, Mr. Albert Kahn, and by all those whom he chose for its construction. An incident of this was expressed in the presentation of an American flag to Miss Emily A. McLaughlin, principal of the Farrand Training School, who was the chief nurse of Base Hospital No. 17, by the workmen on the building to commemorate the fourth anniversary of the departure of the nurses from Harper Hospital for France. Almost the entire personnel of Base Hospital No. 17 were Harper Hospital physicians and nurses.

Mr. Kahn gave his personal supervision to the finishing and decorating of the reception and living rooms. Aside from this, instead of the services of a decorator, the selection of furnishings and the details of this beautifully appointed home have been in the hands of the matron, Mrs. Bessie Bright. Mrs. Bright's artistic training and gifts as well as her wide experience in hospital life have made it possible for her to combine beauty, comfort and utility so that an atmosphere of restfulness prevades the entire home.

This is the first memorial that has been dedicated to nurses of the World War but we trust it will not be the last.

Many lives and much property are lost every year because of accidents due to venereal diseases, says the U. S. Public Health Service. So great in fact are these losses that the National Safety Council has issued a bulletin on them. For instance, four serious recent railway wrecks were traced to employes who failed because they were suffering from paresis, which is a form of syphilis.

Slavery is but half abolished, emancipation but half completed, while millions of freemen with votes in their hands are left without education.—Robert Charles Winthrop.

WHAT THE SMALL HOSPITALS PAY THEIR SUPERINTENDENTS

By JOSEPH J. WEBER, Managing Editor, The Modern Hospital, Chicago.

APPROXIMATELY $150 is the average amount of the monthly salary check handed the men and women—mostly women—who superintend the hospitals of less than 100 beds throughout the United States. To this must be added an additional $45, the average amount which their maintenance costs the hospitals. In other words, the average monthly salary of the superintendents of our smaller hospitals is about $200, according to statistics compiled by The Modern Hospital, based on data gathered from hospitals the country over.

In order to obtain authentic, broadly representative information on this subject, questionnaires were mailed to 900 hospitals having a capacity of less than 100 beds, selected from the various states in the ratio which the population of each state bears to the population of the United States. The response was most gratifying; 464 hospitals or fifty-two per cent of the total sent the data requested.

In order to analyze and compare the salaries received by these superintendents more readily the hospitals in the list were placed in four classes: 1 to 24 beds; 25 to 49 beds; 50 to 74 beds; 75 to 99 beds.

76 Per Cent Head Training School

Those familiar with the hospital field know, of course, that a large majority of the smaller hospitals are superintended by women. It is therefore interesting to observe that 398, or 86 per cent, of the 464 hospitals under consideration have women superintendents. Their salaries* range from an average of $169.93 for hospitals with fewer than 25 beds to an average of $203.47 for hospitals in the 75 to 99 bed group. Two women superintendents, one the superintendent of a 40 bed Methodist hospital located in a small town in the middle west, the other the superintendent of a 30 bed private hospital in one of the largest mid-western cities, receive salaries of $300 and $360 respectively. One superintendent of a 75 bed hospital receives as little as $75 a month.

Of the 464 hospitals 417, or 90 per cent, conduct nurses' training schools. In all but 111, or 24 per cent, of these hospitals the superintendent also acts as the head of the training school. The increased work and responsibility this additional function involves do not, however, seem to play any marked part in fixing the superintendent's salary, for an examination of the appended list will show that often the superintendent of a hospital who does not act as the head of its training school receives a higher salary than the superintendent of a hospital of the same size who does stand at the head of its school.

Men Command Higher Salaries

Of the sixty-six men superintendents, seventeen serve hospitals in the 25 to 49 bed group, twenty-eight in the 50 to 74 bed group and twenty in the 75 to 99 bed group. Their average salaries are higher than the salaries of the women superintendents in the same groups. In the 25 to 49 bed group, their average salary is $39 higher; in the 50 to 74 bed group, $67 higher; and in the 75 to 99 bed group, $96 higher. The highest salary paid a man superintendent by the hospitals listed is $458, plus maintenance. He is the superintendent of an 80 bed hospital in the east. The lowest salary is $100. Three or four receive $125 a month.

The data collected show that the superintendents of 303 hospitals, or 65 per cent of the hospitals listed, have had increases in their salaries, mostly during the past two years. They range from $5 to $141 a month, with an average of $28 a month. On an average salary of $195, this represents about a 14 per cent increase. Of the 464 superintendents reporting only two had salary decreases; the amounts were $50 and $27 a month.

A comparison of the salaries received by superintendents of nurses with the salaries received by the heads of other departments is interesting. In the March issue of The Modern Hospital it was pointed out that the average salary of the superintendent of nurses of 228 hospitals of all sizes was $1,868 a year, exclusive of quarters, subsistence and laundry. This makes an interesting comparison with the almost similar figure of $1,794.12, the average salary of the superintendents of the hospitals of less than 100 beds. Previous salary studies (May and June, 1922) show that the average monetary salary of the superintendent of the hospitals of less than 100 beds is $590 more than the average salary of the dietitians, and $266 more than the average salary of the social workers. It will be apparent,

*Unless otherwise stated, when the term salary is used in this article, it includes not only the monetary salary but also the estimated monetary equivalent of maintenance.

of course, that the individual salaries of both dietitians and social workers, especially those connected with the larger hospitals, are often equal to or in excess of the salaries of many of the superintendents of the smaller hospitals.

No Minimum Standard Recognized

The results of our studies of the salaries of superintendents in general, of the superintendents of small hospitals, of the superintendents of nurses, of dietitians and of social workers, give us no evidence of the recognition of a minimum standard for the salaries of superintendents and heads of departments of hospitals of various capacity and character of service. Whether the establishment of such standards, subject to revision from time to time as the cost of living fluctuates, is practicable is of course a question. Its consideration, however, lies beyond the scope of this article. Might it not be well for the national organizations representing these groups to give the subject more consideration than they have hitherto? Such a service would be immensely valuable to boards of trustees and others in whose hands in the aggregate lie the employment and salary adjustment of no small army of workers.

The tabulations on which the conclusions of this article are based are as follows:

Detailed Information Regarding Salaries Paid Superintendents of 464 Hospitals Having Less Than 100 Beds

1 to 24 Bed Group

Thirteen hospitals, or 2½ per cent of the 464 hospitals under consideration.

Average monetary salary	$120.83
Average maintenance	49.10
Number of women superintendents	12
Number of men superintendents	1
Average salary of women superintendents	122.72
Salary of man superintendent	100.00
Date of first increase	1919
Date of last increase	Nov. 1921
Average increase	21.00
Smallest increase	15.00
Largest increase	50.00
Number with school of nursing	10
Number without schools of nursing	3
Number in which superintendent acts as head of training school	9

25 to 49 Bed Group

One hundred and forty hospitals, or 32¼ per cent of 464 hospital under consideration.

Average monetary salary	$140.53
Average maintenance	41.49
Number of women superintendents	123
Number of men superintendents	17
Average salary of women superintendents	136.00
Average salary of men superintendents	175.00
Date of first increase	1918
Date of last increase	June, 1922
Average increase	25.00
Smallest increase	5.00
Largest increase	75.00
Decrease (1)	50.00
Number with schools of nursing	114
Number without schools of nursing	26
Number in which superintendent is head of training school	96

50 to 74 Bed Group

Two hundred and fifteen hospitals, or 46 per cent of the 464 hospitals under consideration.

Average monetary salary	$157.83
Average maintenance	45.00
Number of women superintendents	187
Number of men superintendents	28
Average salary of women superintendents	149.00
Average salary of men superintendents	216.00
Date of first increase	1918
Date of last increase	May, 1922
Average increase	28.00
Smallest increase	5.00
Largest increase	141.00
Number with schools of nursing	199
Number without schools of nursing	16
Number in which superintendent is head of training school	140

75 to 99 Bed Group

Ninety-seven hospitals or 20 per cent of the 464 hospitals under consideration.

Average monetary salary	$178.87
Average maintenance	44.47
Number of women superintendents	77
Number of men superintendents	20
Average salary of women superintendents	159.00
Average salary of men superintendents	255.00
Date of first increase	June, 1917
Date of last increase	May, 1922
Average increase	33.00
Smallest increase	10.00
Largest increase	100.00
Decrease (1)	27.00
Number with schools of nursing	94
Number without school of nursing	3
Number in which superintendent is head of training school	61

Salaries of Superintendents of 464 Hospitals Having Less Than 100 Beds

1 to 24 Bed Group

No. of Beds	Sex of Supt.	Monetary Salary	Equivalent of Maintenance	Last Increase	Date of Last Increase
15	F	$175.00	$40.00	$50.00	Oct., 1920
*16	M	100.00	75.00		
20	F	150.00	40.00	25.00	June, 1921
†20	F	125.00		15.00	Oct., 1921
20	F	100.00	50.00		
20	F	100.00	50.00	25.00	June, 1920
20	F	100.00	46.00	15.00	Jan., 1921
20	F	100.00	0		
21	F	125.00	50.00	25.00	Nov., 1921
22	F	100.00	25.00		
*24	F	150.00	65.00		
24	F	125.00	40.00	25.00	April, 1920
24	F	100.00	40.00		

25 to 49 Bed Group

25	F	125.00	40.00	25.00	Sept., 1920
25	F	125.00	18.00		
25	F	150.00		25.00	1919
25	F	100.00	26.00	15.00	1921
25	F	125.00	5.00		
25	F	100.00	40.00		
*25	F	150.00	60.00		
†25	M	125.00			
25	F	150.00	50.00	25.00	April, 1922
25	F	125.00	48.00	25.00	Nov., 1921
*25	F	125.00	25.00		
25	F	100.00	40.00		
25	F	115.00	45.00		
25	F	100.00	40.00		
*25	F	150.00		25.00	Feb., 1921
25	F	125.00	35.00		June, 1920
25	F	200.00	40.00	50.00	Feb., 1922
*25	F	125.00	17.75	25.00	Jan., 1920
25	F	150.00	40.00	25.00	June, 1921
25	F	125.00	50.00	25.00	Jan., 1921
26	F	140.00	95.00	15.00	Jan., 1920

A star (*) indicates the absence of a training school. A dagger (†) indicates that the superintendent is not the head of the training school. Where no star or dagger appears the hospital has a training school and the superintendent acts as its head.

(Continued on page 232.)

ORGANIZING THE MEDICAL SERVICE OF A STATE HOSPITAL

By A. L. BOWEN, Former Superintendent of Charities, Illinois Department of Public Welfare, Springfield.

IN THE August issue of THE MODERN HOSPITAL an attempt was made to outline the necessary medical personnel of a state hospital. In this number will be described how such medical service may be organized to secure the best results.

If the state operates a group of mental hospitals, it should have a central psychiatric institute and hospital with laboratories equipped to do the more highly technical work that the various hospitals in the group may not be prepared to do. If the state has only one state hospital, it should be organized to serve the purposes of the central institute and hospital.

"Institution life is a life of ruts and routine. Staff men themselves may determine that it shall be otherwise. Contact with each other in other than professional relations, contact with the profession in the community, contact with the people of the community through religious, social and welfare orders are all possible. Staff members are too prone to overlook their opportunities. The average medical staff degenerates because it is not properly organized and stimulated to intensity, to study, to research, to vision and imagination and to professional esprit de corps. Yet there is no place in medical practice where opportunities are greater or go to waste with such prodigality."

Institute is Research Center

This institute becomes the teaching and research center of the state. The psychiatric hospital in connection should be reserved for acute mental and nervous cases; voluntary admissions, so far as possible. Physicians of the various medical staffs may be summoned to this institute in groups for periods of instruction each year. Members of the staff of the institute or its director may visit the various hospitals at intervals to check up on the work of local medical officers and to lecture both to the medical and nursing service. To all such lectures and clinics the practitioners in the community should always be invited.

The training school for psychiatric nurses, and the training school for psychiatric social workers may be conducted at this central point from which also may be directed mental clinics and dispensaries in the civil communities throughout the state.

In other words this institute becomes the seat of inspiration, the center of research, learning and instruction, the maker of standards, the barometer of the service in the state and the recognized authority on mental and nervous diseases in both state and private practice.

Each hospital must be organized and equipped to make use of such a staff as was previously outlined. Wards for the physically sick may be located anywhere in the institution, but a detached building is to be preferred; one just large enough to accommodate the patients who are suffering from acute physical illness. The infirm, ambulatory and convalescent do not belong in this department. The institution hospital should be a modern general hospital. It should have operating rooms, quarters for all manner of dispensary service, dentistry, laboratories, morgue, classrooms for the local training schools for nurses, occupational therapists and attendants and an x-ray department; in short, everything that goes to make up a modern general hospital must be included. No state hospital can be complete without such a hospital service centered in a detached structure.

In every state hospital there are many aged, infirm, cripples and chronic sufferers of various types not needing bedside attention. For them special types of wards are very important. Detached buildings are to be desired but wards for them may be organized wherever there is plenty of sunlight, good ventilation, easy exit to the grounds and ample toilet and bathing facilities. Wards for convalescents are next to be considered. As soon as patients may be removed from the general hospital they should be taken into attractive quarters where the opportunities for speedy acquirement of strength are good. Special diet is as necessary here as in the hospital or in the infirmary.

Segregation of Tuberculous Patients

No longer may tuberculous patients be tolerated on the wards, scattered indiscriminately throughout the institution, yet this is the practice in many states. This type of patient is very undesirable in the main buildings if the institution happens to be congregate. Detached structures for tuberculous men and women are essential. These may be built without great expense and

should follow the lines of the established sanatoriums for civil patients. There are certain refinements in these buildings not required in the civil sanatorium. Bathing and toilet facilities must be more numerous, and must be nearer the beds. Provision must be made to keep the floors warm, because insane patients will elude nurses and get upon their feet. Flies are more of a problem in the "T B" wards of a state hospital than in a civil hospital; the tuberculous mental patient is much more of a menace than a civil patient because he seldom exercises any of the precautions which the sane patient will follow under direction. There must also be additional possibilities for isolation and separation of types and classes.

Dispensary Service is Desirable

Dispensary service in a state hospital is possible and will save medical men many steps. All inmates, not in special hospitals, convalescent wards or infirmaries may go to a central dispensary for whatever attention they may require. An attendant or nurse may accompany them or they may go in parties under the supervision of a paroled patient. Going to and from the dispensary is not a problem at all, though doubtless many administrators will look upon it as an insurmountable obstacle. The success of the open institution where it has been tried indicates that the dispensary service would be successful.

The reception service which includes all acute mental cases should be organized as near as possible to the hospital's surgical, laboratory, x-ray and dentistry services. Under this plan everything pertaining to the medical care and treatment of the population of the institution is centralized for the convenience and the inspiration of the medical men and the benefit of those needing attention. This plan gives every doctor his share in the medical service and removes from his duties routine matters which can be handled just as well by laymen.

For instance, as commonly organized, the state hospital assigns to each physician a group of wards over which he is supreme in practically all subjects. He visits his wards two or three times a day. These visits many times are perfunctory. I have seen a doctor rush into a ward, ask the charge nurse if there is anything needing his attention and dash out. Perhaps she told him that the radiator in the north dormitory is leaking or John Smith needs a new suit of underwear.

Physicians' time should not be consumed in this manner. Seventy-five per cent of the institution's inhabitants are chronic patients who seldom require a doctor. Some physicians must draw this routine. They seldom have occasion to prescribe. They soon drift into a rut, neglect their reading, grow stale and finally become institutional parasites. One or two draw the active, attractive service but there is lacking in the prevailing organization any incentive for them to do progressive, up-to-date, medical work, because of so much deadening routine and degenerating influence.

Superintendent Need Not be a Doctor

Many states, perhaps all of them, are laboring under the false impression that a state hospital must have a physician as superintendent. This is a fallacy. The superintendency requires a man of executive capacity and administrative ability and experience. If he is also a physician, it is well, but the position does not in any manner demand that a physician fill it. The superintendent has little time to give to medicine. Business affairs consume all his energy. The medical side may safely be entrusted to a live, modern young man, trained and experienced liberally in general and special medicine. He should of course be developed in the field of nervous and mental diseases. To him should be given the responsibility for everything medical: nursing, nursing schools, social service, occupational therapy, recreation, amusement and pretty much all that contributes to the physical or mental welfare of patients.

No attendant person should be placed on a ward until he has undergone a course in training. Each institution should have a training school for attendants where each applicant, as he enters, is required to take it and pass a reasonable examination, after which he would be eligible to active employment with patients.

The training school for nurses must emphasize mental nursing but there is no reason why it should not graduate women qualified to take the state examination of registration.

If students lack the preliminary education when they enter the service, let the institution provide it, either in classes within the grounds or in the high school in the community nearby. Every state hospital needs a corps of registered nurses as the nucleus of its nursing and attendant service.

Occupational therapists and occupational aides must get their practical training in state hospitals; there is no other place that can give it. Theory may be acquired in special schools but the field work with mental patients may be had only in state hospitals. Every state hospital, therefore, should organize classes for this type of worker.

Daily it becomes more and more apparent that employment, however light or unimportant it may be, is vitally necessary to the welfare of mental

patients. The so-called untidy wards are without excuse for their existence. Patients who mill and fight, tear their clothing and engage in damaging and dangerous practices are perforce of their idleness compelled to do these things. Energy expended in this manner may just as well be directed into useful or at least innocent channels with a very great improvement in the physical being. To be abreast of the times and to give modern care to mental patients, a state hospital must be able to carry on occupational therapy on every ward and among all patients, who are neither sick nor otherwise incapacitated. Convalescents above all should have employment for mind and hand. The success of all these schools depends upon the medical staff which must furnish the teachers and the inspiration. The assignment of mental patients to occupation or employment, to recreation and special or habit training is a part of the duty of the medical service.

Every local staff should have its club for social and professional purposes. Institution life is a life of ruts and routine. The men themselves may determine that it shall be otherwise. Contact with each other in other than professional relations, contact with the profession in the community, contact with the people of the community through religious, social and welfare orders are all possible. Staff men are too prone to overlook their opportunities.

But primarily I believe that the average medical staff goes stale and degenerates because it is not properly organized and stimulated to intensity, to study, to research, to vision and imagination and to professional esprit de corps. Yet there is no place in medical practice where the opportunities are greater for all these things or go to waste with such prodigality.

A SUNNY HOSPITAL WARD

Wide World Photos.

An open-air ward at Lord Mayor Treloar Cripples' Hospital at Alton, England, where the curative powers of the sun's rays are being utilized.

TORNADO DAMAGES ARMY HOSPITAL

Roofs were torn off, windows smashed, beds hurled across the wards and other damage done on July 14 when the Fitzsimons General Hospital, a government institution near Denver, became the center of a small tornado. None of the patients was injured.

A terrific wind carried the roof off the main hospital building and dropped it 100 feet away. Roofs of seven other buildings were partially wrecked, hundreds of windows were broken, tennis courts were demolished, the Red Cross building was damaged and the electric and water systems were put out of operation by the brief storm. The beds occupied by several ex-soldier patients were said to have been blown across the wards, but in spite of the showers of glass and flying timbers, all patients escaped injury.

The damage was estimated at $50,000. The storm was purely local in nature and aside from an unusually high temperature for six o'clock in the evening, nothing unusual in the weather conditions was noted.

ROCKEFELLER FOUNDATION AIDS HOSPITAL AND HEALTH WORK

Among the gifts of the Rockefeller Foundation during 1921 for hospital and health purposes, the following are enumerated in the president's report recently issued:

Pledged $2,000,000 to Harvard for a school of health.

Continued the $250,000 annual appropriation for Johns Hopkins school of hygiene and public health.

Contributed large sums to public health in Czechoslovakia, Brazil and the United States.

Promoted the cause of nurse's training in the United States and Europe.

Underwrote an experimental pay clinic at Cornell University medical school.

Opened the hospital and medical school at Peking, China, and assisted twenty-five other medical schools in that country.

Pledged $1,000,000 for Columbia University medical department.

Contracted to appropriate $3,500,000 for rebuilding the medical school and hospital of the Free University of Brussels.

Made surveys of medical schools in Japan, China, Philippines, Indo-China, Straits Settlements, Siam, India, Syria and Turkey.

Supplied American and British hospital and medical journals to 112 medical libraries on the European continent.

Supplemented the laboratory equipment and supplies of five medical schools in Europe.

Paid expenses of commissions from Great Britain, Serbia, and Brazil.

Provided 157 fellowships in hygiene, medicine, physics and chemistry to representatives of eighteen countries.

Continued a campaign against yellow fever in Mexico, Central and South America.

Conducted demonstrations in the control of malaria in ten states.

Cooperated in hookworm work in nineteen governmental areas.

Participated in rural health demonstrations in seventy-seven American countries and in Brazil.

Provided experts in medical education and public health for many parts of the world and rendered other services to governments and voluntary societies.

THE RADIOLOGICAL CLINIC OF THE PHILADELPHIA GENERAL HOSPITAL

By JOSEPH C. DOANE, M.D., Medical Director, General Hospital, Philadelphia

PHILADELPHIA was the first city in this country to purchase radium for the treatment of neoplastic disease in a municipal hospital. Save in a few instances where large clinics were available for the diagnosis and treatment of tumors, the expense of this treatment has heretofore made it available only to the wealthy. Not only does the purchase of an ample supply of radium provide for the treatment of patients at the Philadelphia General Hospital who could not otherwise receive adequate care, but it opens up wide possibilities of research, adding to the store of scientific information concerning this element and its place in the treatment of disease.

It is the policy of the department of public health to proceed very slowly in the development of the radiological clinic at the Philadelphia General Hospital. After months spent in constructing a suitable clinic suite, during which every detail was given the closest attention, the clinic was made ready for the beginning of actual work late in 1921. A staff of specialists was appointed and held its first conference on January 23, 1922. This conference meets each Monday, at noon, and is attended by all the members of the staff with their assistants. The staff, as organized, consists of a dermatologist, surgeon, urologist, gynecologist, radiologist, laryngologist, oral surgeon, internist, pathologist, physicist and senior assistant medical officer.

Treatment room in Philadelphia Radiological Clinic.

Each visiting chief has a designated hour for conducting his clinic, at which time all treatments are given and return cases examined. It is possible by this system for twenty or thirty cases to be seen daily. There have been assigned to the department eighty hospital beds which can be utilized for the care of patients suffering with neoplastic disease. Since certain patients may require applications, ranging in time from two to twelve or fifteen hours and will need observation during this time, two four-bed wards with diet facilities have been constructed in the clinic suite, where ambulant cases may be treated without entering the hospital proper.

Reception room in Radiological Clinic.

Since radium and x-ray are used conjointly in the treatment of neoplastic disease, it became necessary to purchase new equipment for the last-named department and to completely rearrange and reorganize the apparatus formerly used. A high-voltage machine with a twenty-inch spark gap, the first of its kind in the city, has been ordered and will be ready for use shortly. It has been thought best to divide the work of the x-ray department between two visiting physicians, one to have charge of the therapeutic and the other of the diagnostic work only. The new electrothermic method of coagulation, which is an established mode of procedure for removing the foul and exuberant sloughs in advanced cases of malignancy, is to be used in connection with this department.

The nursing staff of the radiological department consists of a graduate nurse in charge of

Ward for ambulant cases requiring 24 to 48 hours for treatment.

the clinic, and one for each of the wards, with an appropriate number of pupil nurses, as required by the exigency of the service.

In order that there may be the proper coordination of the efforts of the radiological staff, a full-time resident radiologist was secured, who with his assistant closely follows the ward treatments, supervises dressing and is responsible for placing and removing all radium applications.

It has been thought best, when possible, for patients to be referred by their physicians for treatment either in the out-patient department or in the hospital wards. In this way the staff is aided by being able to secure a medical history of the development of the disease, as well as to arrange for the continued interest of the family physician, who referred the case, after the patient has been discharged from treatment. Patients who have not consulted a physician may apply at the radiological department of the Philadelphia General Hospital for treatment daily, except Sunday, from 9 to 10 a., m. at which time they will be examined by the resident medical officer and referred to the proper clinic for treatment.

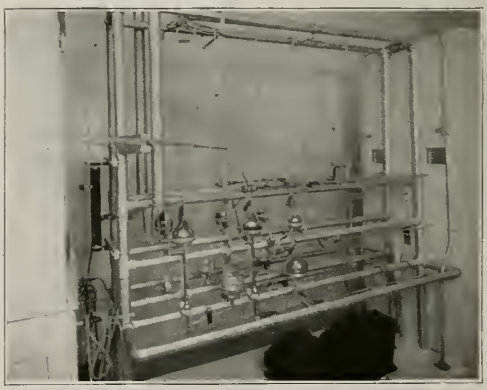
The radiological staff desires the cooperation of all members of the medical profession in referring cases of neoplastic disease early to the clinic for treatment, since it feels that no measure can be efficacious if the disease is allowed to progress to a late stage. In order that the service of this clinic may be of the greatest value to the people of Philadelphia not only are marked and easily diagnosed cases of neoplastic disease referred to the clinic but also cases of uncertain diagnosis for thorough study by the radiological staff. Nor are malignant conditions only referred to the clinic, since the medical profession recognizes that there are many benign conditions which yield readily to treatment by radium and x-ray. Angiomata, unsightly nevi, keloids, and benign uterine hemorrhages of myopathic origin, as well as certain types of bleeding myomata, frequently yield to treatment by these agents.

The physical laboratory of the radiological department of the Philadelphia General Hospital was formally opened on November 30, 1921.

This division consists of an emanation room with its contained apparatus for the withdrawal of radium emanations from the two grams of radium; a technical toolshop where apparatus and instruments used in the preparation and application of radium emanations in the treatment of disease are constructed; a measuring room where the emanation is properly valued; and a preparation room, which is located in the out-patient department. The emanation apparatus, as well as other features of the equipment, has been patterned after that now in use in the Memorial Hospital, of New York. Certain improvements, however, have been embodied in the building of this apparatus, these changes being largely the result of the wide experience of the members of the Memorial Hospital staff in the preparation and application of radium. As a result, the equipment at the Philadelphia General Hospital is probably the most modern and complete possessed by any radiology laboratory in the country.

Interior of safe containing two grams of radium from which emanations are collected daily.

The two grams of radium are kept in a lead-



Apparatus for collecting tubes of radium emanation, showing details of vacuum system.

lined safe in the emanation room, which is safeguarded by an elaborate burglar-alarm system and watchman.

About three hundred millicuries of emanation are collected every twenty-four hours and are placed in capillary tubes, which are later measured and forwarded to the out-patient department for application. Before the emanation is transferred from the laboratory to the out-patient department careful measurements are taken and the results are recorded in the measuring room on the third floor of the laboratories. The measurements are made by noting the time in seconds required to discharge an electroscope by a known standard of 25.24 milligrams of radium bromid, and comparing the time required to discharge the electroscope by the unknown tube of emanation to be measured. Taking into consideration the natural leak of the charge from the electroscope, the strength of the unknown tube can be computed.

Ionization chamber and galvanometer used to measure the relative strength of used emanation tubes.

The technician in the preparation room prepares applicators in accordance with the request of the physician attending the patient. A careful record is kept of each tube, and this record is corrected daily at the same hour in accordance with the known rate of decay. This system makes it possible to know at any time the total amount of emanation available for use.

A second measuring room is maintained in the radiological clinic to determine the strength of small bare tubes of 0.75 to 1.5 millicuries. These measurements require fifty to sixty operations, depending upon the number of bare tubes. After the measurements are recorded about 100 mathematical operations are performed to get the strength of each tube.

The routine just described, which makes possible the transfer of pure emanation from the radium solution in the laboratories in a form suitable for treatment, is carried on by a physicist, a technician and a glass-blower.

In order to make possible creditable research work, a well-equipped shop has been established, where not only appropriate apparatus can be made for carrying on investigations with radium emanation but also where special apparatus for the application of radium emanation in the radiological clinic can be made.

There has been considerable interest along research lines shown by the various departments of the laboratories, and already work on six research problems has been started with the co-operation of the radiological department.

A radiological library is being collected to facilitate research work. It will be located in the radiological research room of the laboratories and will be available to those actively interested.

Shop equipped for making mechanical apparatus and for glass blowing.

Preparation room used for making various types of applicators.

LABORATORY FORMS FOR HOSPITALS

By HENRY J. GOECKEL, Phm.D., Cranford, N. J.

SINCE no set of laboratory report forms has been recommended to date by the American Hospital Association as a standard, a description of those prepared by the writer and used in Muhlenberg Hospital, Plainfield, N. J., may be of interest at this time.

The Muhlenberg Hospital forms were prepared not only to meet the needs of the laboratory; they also take into consideration the requirements of the nursing staff as well as those of the medical staff and of the historian of the institution. Their aim is to give a report which can be readily visualized, the essentials not being buried in a maze of "absent, normal or negative" notes. To note a multitude of unnecessary facts not only detracts from the value of the report but adds greatly to the time necessary to write reports and causes confusion in summing up and in posting the same.

Should Have Standard Examinations

Every well manned and properly supported laboratory should have standard types of examinations. Where the tentative or working diagnosis is not stated on the request form accompanying a specimen, a minimum only should be resorted to. Where such a diagnosis is stated the tests and methods should be modified and extended to confirm, extend or alter this diagnostic conclusion. By this means the time and resources of the laboratory are not wasted and in a measure this department will contribute to the maintenance of medical standards by making a working diagnosis an essential requisite for extensive laboratory aid. It will tend to compel a prompt physical examination and diagnostic conclusion and to prevent the all too prevalent habit of waiting for laboratory reports before forming a definite opinion.

Every hospital aspiring to be a first class institution should make it a rule that no laboratory reports will be given until a working diagnosis has been posted on the chart. By necessitating prompt physical examinations and history charting, this contributes to maintaining efficient physical diagnostic methods and tends to prevent the laboratory methods from overshadowing such basic methods. It will help to maintain laboratory procedures as a confirmatory aid and not as the major means to a diagnosis.

Symbols Should Be Used

Beside eliminating unnecessary topics on report forms, as far as it is possible to do so, the following symbols are used in place of words in reporting. N. for normal, (—) for negative or absent, (±) for doubtful tests or results, (+) for slight traces or few, (++) for distinct traces or moderate number, (+++) for distinct tests or numerous, (++++) for a very strong test or for very numerous, (?) for no results where factors are missing, Ac. for acid, Alk. for alkaline, Sl. for slight, P. for pale, D. for dark, (%) for per cent, CC. for cubic centimeter, mg. for millegram, cmm. for cubic millimeter. Where these symbols are used their value is printed on all forms.

Our request or consultation forms are prepared in pads of sheets four by six inches (10x15 cm.). These are used to accompany all specimens excepting routing urines. They are more practicable than the case history size forms, are less bulky and easier to keep in the nurses' desks. They are more convenient when accompanying specimens as they can be attached to containers with the aid of an elastic band or a pin without folding. Specimens can be transported more conveniently and placed more compactly on the receiving trays. The inconvenience of large forms causes breaking and spilling of specimens or loss of time and space. These forms are to convey requests and instructions to the laboratory and

MUHLENBERG HOSPITAL

PLAINFIELD, N. J.

SPECIMEN FOR PATHOLOGICAL LABORATORY

Lab. No.....

Name .....

Ward or Room.....Date.....

Service of Doctor.....

Diagnosis .....

.....

Specimen of
From

Obtained At A. M. P. M.

If by special technic—state

To be examined for

To be used with sputum, feces, blood, milk, cultures, etc.

For urine, use other forms.

To be signed by nurse or physician making out this form and sent direct to the laboratory.

Fig. 1.

should be retained there as part of its records.

This form (Fig. 1.) besides giving the name of the institution states that it accompanies a "Specimen for Pathological Laboratory" or "Request for Pathological Laboratory." A space is provided for the laboratory record number. No space is provided for noting the time when the request or the specimen was received at the laboratory. This being purely laboratory data its appearance on the printed form before reaching the laboratory is likely to cause confusion. If a receiving clerk or statistician is employed to receive specimens, he or she can record them numerically in the day book and then enter the record number and the time on the request form.

A space is provided for the patient's name, the ward or room, the date, the attending physician's name and a liberal space for the working diagnosis. The form calls for the designation of the kind of specimens, the organ or region, etc., from which it was taken, how it was obtained, requiring it to be stated when obtained by a special technic, and the time when it was obtained to enable the laboratory staff to know the age of the specimen when subjected to examination. Liberal space is allowed to state for what it is to be examined. The pathologist of course reserves the right to extend the examination beyond that requested if in his judgment the working diagnosis justifies a more extensive examination. The nurse or the physician writing the request is required to sign it. This is to enable the laboratory to establish contact with the person conversant with the case, should further information or instruction be required.

The reverse side of this form can be used to note the results of the examination. As all laboratory reports should be prepared in duplicate on case history size forms, recording results on the face of this form is unnecessary. If deemed of value rubber stamps can be used to stamp on the back the things to be reported on. This is only necessary where inexperienced help is relied upon to make the examinations.

Upon completion of the examination, since all essential data are now on this form, including the record number, the report can be prepared from this and the request form either filed numerically or returned to the clerk for assembling the data according to the statistical requirements of the laboratory and the hospital. At the end of a year these records can be destroyed.

Forms of Urine Examinations

Two kinds of urine report forms are employed. One which is kept in the wards is of the same size as the general request form and is designated as

MUHLENBERG HOSPITAL

PLAINFIELD, N. J.

HOUSE URINE REPORT

Name .....

Ward or Room.....Date.....

Doctor .....

Diagnosis .....

EXAMINATION

Color .....Transparency.....

Reaction .....Odor.....

Specific Gravity .....Sediment .....

Albumin .....

Sugar .....

Bile .....*Urea*.....

Indican ..... *Acetone*.....

MICROSCOPICAL

Casts .....

Epithelia .....

Pus .....

Blood Cells .....

Crystals .....

Amorphous .....

Fig. 2.

the "House Urine Report" (Fig. 2). The same spacing is provided to give the patient's name, ward, date, physician's name and the diagnosis. The first spaces provide for the results of the physical examination, i. e., color, transparency, reaction, odor, specific gravity and sediment. Then come spaces to provide for chemical data, i. e., albumen and sugar, and in smaller type for bile, urea, indican and acetone, which are only examined for and reported on in casual routine urines when specially requested.

Under the heading of microscopic examination, space is provided for casts, epithelium, pus, blood, crystals and amorphous substances.

No record of these routine urine examinations is kept in the laboratory. The form accompanying the specimen, with the results of the examination noted thereon, is returned to the wards where the results are posted on the special laboratory form to be described later. When posted the slip is destroyed and not preserved with the history. This keeps down the bulk of the history forms and avoids confusion.

For complete clinical examinations on twenty-four hour specimens of urine, on cystoscopy and on renal function test specimens, a special form of case history size and style is employed (Fig. 3).

MUHLENBERG HOSPITAL
PATHOLOGICAL LABORATORY
PLAINFIELD, N. J.

Path. No. Date 9/14/21 Time voided Ward
Name Mrs. K. H Service of Dr. R. Y. M
Diagnosis (Tentative)

URINE EXAMINATION Renal Function 9/15/21

Cystoscopic 9/14	Bladder	Left Ureter	Rt Ureter	Present	2 hrs	1 hr	2 hrs	Total
Color	N	N	N	N				
Volume	?	8 c.	8 c.	250 cc	100 cc	298 cc	58 cc	
Appearance	cl	cl	cl	cl	cl	cl	cl	
Sediment	++	++	++	++				
Reaction	ac	ac	ac	ac				
Specific Gravity	1014	?	?	1020	?	1.016	1016	
Albumen	+	±	—	+				
Sugar	—	—	—	—				
Occult Blood	—	—	—	—				
Urea	1.4 %	?	?	1.8 %				
Bile	—	—	—	—				
Indican	N	N	N	N				
Acetone	—	—	—	—				
Diacetic Acid	—	—	—	—				
Creatinine	N	N	N	N				
Total solids						3.35 gm	2.42 gm	
Time					9 min.			
Phenol-Sulphone-Phthalein						30 %	13 %	43 %

MICROSCOPIC EXAMINATION

Casts Hyaline	—	—	—	—				
Casts Granular	—	—	—	—				
Epithelium	N	++	+	N				
Pus Cells	++	++	—	++				
Blood Cells	—	—	—	—				
Crystals	—	—	—	—				
Amorphous	—	—	—	—				
Mucus	++	—	-	++				
Bacteria								
Staphylococci	+++	++						

NOTE: (-), = None ± doubtful trace or test, +, slight trace or few; ++, distinct trace or moderate number; +++, distinct test or numerous; ++++, very strong test or very numerous; N, normal.

Examined by H. J. Goechel

Fig. 3.

This is of a pale blue color and can be used for practically all kinds of urine examinations. The first line provides for the pathological laboratory record number, the date, the time when voided and the ward designation. The next line provides for the name of the patient and of the physician who has charge of the case. The third line provides for the diagnosis which accompanied the request.

The form is ruled to permit eight reports to appear in parallel columns. This allows the form to be employed not only for a general clinical report but also for cystoscopy reports, for the results of a fractional series such as the Mosenthal functional test, and for the results of the phenolsulphonephthalein test. These are reported on more extensively by this laboratory than is the case in most hospitals, as will be seen by the reports posted on the illustration to give an idea of its adaptability to the needs of the institution.

Where several clinical examinations have been reported on the same case, eight of them can be posted on the same sheet, thereby eliminating seven sheets from the filed history. At the same time the results of all the examinations are shown by convenient contrast.

At the top of each column a space is provided for entering a descriptive designation to show if the specimen is a twenty-four hour one, or the date of voidance, or if it is a voided, a catheterized, a bladder or a right or a left ureter specimen. Then in consecutive order there are spaces for the color, volume, appearance, sediment, reaction, specific gravity, albumen, sugar, occult blood, urea, bile, indican, acetone, diacetic acid and

Path. No. Date May 9, 1921 Time 9 A.M. Ward
Name M. H. Service of Dr. L. J. W.
Diagnosis (Tentative) Pernicious Anemia

BLOOD EXAMINATION

Coagulation Time
Hemoglobin 36.5% Index 0.970
Erythrocytes per Cmm 1,852,000
Polychrome cells.. 10,500
(Reticulated... 3,500
Normoblasts.... 587
Megaloblasts.... 1,760
Shadow cells... 5,060
Plasmodia None
Agglutination for —

Leucocyte Index
White Cells per Cmm 1,400
Differential Count
Total Leucocytes . . . . . 36.2 %
Polymorphonuclears
Neutrophiles . . . . . 28.4 %
Eosinophiles . . . . . .4 %
Basophiles . . . . . —
Mononuclear Leucocytes } 6.4 %
Transitional Leucocytes }
Irritation Leucocytes . . 1.0 %
Total Lymphocytes 63.8%
Small Lymphocytes . . . 55.4 %
Large Lymphocytes . . . 8.4 %

Complement Fixation Tests
For Syphilis - negative
For Tuberculosis —

mg. per 100 cc.	Normal	Found
Creatinine	0.5 - 1.2	
Urea	5.0 - 24.0	
Uric Acid	0.5 - 3.0	
Sugar	50.0 - 100.0	
Chlorides	520.0 - 595.0	

Hydrogen - ion Concentration or
Alkali Reserve
Bicarbonate Content
CO_2 Tension of Alveolar Air

Culture of Bacteria:

Camera stretch of red cells.
08. ½ oil Oc. ½
160 mm

Examined by H. J. Goechel

Fig. 4.

creatinin. Four blank spaces follow for occasional tests and then one for the phenolsulphonephthalein test.

Under the heading of microscopic examination space is provided for hyaline casts, for granular casts, for epithelium, pus, blood, crystals, amorphous material, mucus and for bacteria. When the present lot of forms is exhausted a space will be provided for cylindroids and one for cultures. The printer gave too much prominence to the note on the symbols used. A more liberal space was to have been left after the word "bacteria" to permit posting remarks where indicated.

The part reserved for microscopical examination should have been ruled in the same way as the rest of the form.

Forms for Blood Examinations

The report form for blood examinations is of case history size and of an orange yellow color (Fig. 4). Besides having the same heading as the urine report form, the sheet is blocked off into six parts. The upper left side has headings for the coagulation time, hemoglobin per cent and hemoglobin index and for the number of erythrocytes per cubic millemeter. Then a liberal space is allowed for a description of the red cells and for noting abnormal forms. A space is also provided for plasmodia and one for an agglutination test. On future editions four spaces will be allowed to permit posting the results of an entire typhoid colon series of agglutination tests.

Following this is a block reserved for complement fixation tests. A space is indicated for the results for syphilis, for gonorrhea and for tuberculosis. Space is allowed for three more headings.

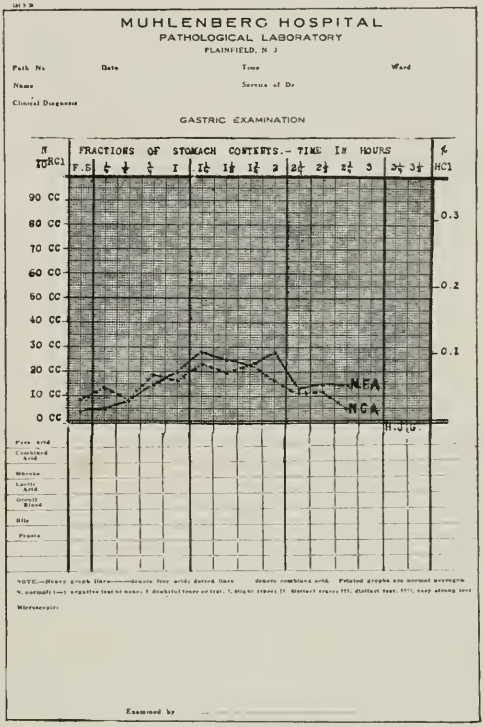
The next block is reserved for noting creatinin, urea, uric acid and sugar in millegrams per hundred cubic centimeters. Space is allowed for entering four more of such examinations.

The right upper block takes up one-fourth of the form and is reserved for the white cell count. Space is provided for the leucocytic index, white cell count per cubic millemeter, and under the heading of differential count is a space for total leucocytes, the figures being carried far to the right beyond where the various types of leucocytes are noted, i. e., polymorphonuclear neutrophils, eosinophils and basophiles, mononuclear leucocytes and transitional leucocytes. Then there is a heading for total lymphocytes followed by subheadings for small and for large lymphocytes. Seven spaces are then allowed for occasional types of white cells.

Below this is a block for the hydrogen in concentration, the alkali reserve and bicarbonate content of the blood, and for the carbon dioxide tension of the alveolar air. Four spaces are allowed for other tests.

Across the sheet where blocked for the results of the blood chemistry determinations is a note, "State if special tests are on weighed or measured volumes of blood or serum." The lower fifth of the form is reserved for culture reports and remarks and for the signature of the examiner, the words "examined by" indicating the place for the signature.

The gastric examination form of a light cream yellow color provides for reporting the results of


MUHLENBERG HOSPITAL
PATHOLOGICAL LABORATORY
PLAINFIELD, N. J.

Path. No. Date Time Ward

Name Service of Dr.

Clinical Diagnosis

GASTRIC EXAMINATION

N/10 HCl — FRACTIONS OF STOMACH CONTENTS.—TIME IN HOURS — % HCl

F.S. ¼ ½ ¾ 1 1¼ 1½ 1¾ 2 2¼ 2½ 2¾ 3 3¼ 3½

90 cc
80 cc
70 cc
60 cc
50 cc
40 cc
30 cc
20 cc
10 cc
0 cc

0.3
0.2
0.1

N.F.A.
N.G.A.

H.J.G.

Free acid
Combined Acid
Mucus
Lactic Acid
Occult Blood
Bile
Pepsin

NOTE.—Heavy graph lines——denote free acid; dotted lines ------ denote combined acid. Printed graphs are normal averages.
N. normal; (-ve) negative test or none; F. doubtful trace or few; +, slight traces; ++, distinct traces; +++, distinct test; ++++, very strong test.

Microscopic:

Examined by

Fig. 5.

the examination of a specimen taken from the fasting stomach and for fractions of the contents at quarter hour intervals for three and one-half hours after a meal. In all space is provided for fifteen fractions, the maximum likely to be obtained in a Rehfuss series.

As will be noted in the illustration, (Fig. 5) following the same headings as on preceding forms, about half of the form is taken up by a graph chart prepared by the writer. At the top is indicated "Fractions of Stomach Contents.—Time in Hours." On the next line "F. S." for fasting stomach appears, and ¼, ½, etc., to 3½ to indicate the time when the fraction was taken. At the zero and hour intervals a heavy line goes down the entire form to block off each hour. To the left of the chart is noted at ten cubic centimeter intervals, the lines for decinormal hydrochloric acid equivalents of the gastric contents, from zero to one hundred cubic centimeters. To the right of the chart is indicated the percentage equivalent by weight of hydrochloric acid, the tenth, two-tenths and three tenths being marked.

On the chart are printed graphs for the types of normal curves for free hydrochloric acid and

for combined acid. These were prepared from averages as ascertained by Hawkes*. The heavy solid line indicates the normal free acid curve (N. F. A.) and the dotted line indicates the normal combined acid curve (N. C. A.) For contrast the curves charted from the examination are most satisfactory when made with a laboratory blue pencil.

Space is provided to note free acid, combined acid, mucus, lactic acid, occult blood, bile and pepsin, and two blanks. Then follows an explanation of the symbols and a liberal space for the microscopic results and remarks followed by the words "examined by."

MUHLENBERG HOSPITAL
PATHOLOGICAL LABORATORY
PLAINFIELD, N. J.

Path. No. Date Time Ward

Name Service of Dr.

Diagnosis (Tentative)

EXAMINATION OF

From (organ or tissue involved)

Obtained by

General Characteristics of Specimen

Color Odor Consistency, etc.

Conclusions

Examined by

Fig. 6.

Loosely combined organic acids are not determined separately as this in the writer's opinion has very little value, not sufficient to waste the time and resources of the laboratory on. Total acid is not reported. Each factor, i. e., the free acid and the combined acid is noted separately. The sum of these being the total acid, it is left to anyone desiring this figure to do his own addition and graphing of it.

Miscellaneous Examination Forms

For other examinations a general form of a gray color is provided (Fig. 6). This provides for the same record data as all preceding forms and then in heavy type at the center are the words "Examination of." On the next line "From (organ or tissue involved)" and "Obtained by" to indicate the method by which it was secured. Five lines of space follow for this, and then "General Characteristics of Specimen" followed by the subheadings "color," "odor" and "consistency" which are noted where appropriate. The rest of the form is blank excepting the lower one-quarter, a heavy line, dividing this from the rest for "Conclusions" and the space to indicate whom it was "examined by." This form is used for tissues, sputa, milk, etc.

*Hawkes' "Physiological Chemistry."

MUHLENBERG HOSPITAL
LABORATORY CHART

NAME J. B. WARD Reb ADMISSION NO DISCHARGE NO

URINE EXAMINATION

NOTE: Use the following symbols in charting (–), None; ±, doubtful trace or test; +, slight trace or few; ++, distinct trace or moderate number; +++, distinct test or numerous; ++++, very strong test or very numerous; N, normal; Ac., acid; Alk., alkaline.

DATE	SP. GR.	VOLUME	REACT.	ALB. NUC.	SUGAR	BILE	ACETONE			CASTS HYALINE	CASTS GRAN.	PUS	BLOOD
1/10/20	1.010	?	Ac	–	–	–	–			–	–	–	–
22	1.012	?	Ac	–	–	–	–			–	–	–	–
30	1.020	?	Ac	–	–	–	–			–	–	–	–
2/11/20	1.022	?	Ac	–	–	–	–			–	–	–	–
5/12/20	1.024	?	Ac	+	–	–	–			–	–	++	–
18	1.030	?	Ac	–	–	–	–			–	–	–	–

Blood Examinations

DATE	HGBL.	INDEX	RED CELLS	WHITE CELLS	POLYNUCLEARS NEUTRO.	POLYNUCLEARS EOSIN.	MONONUCLEARS LEUCOS.	LYMPHO CYTES	Examined
1/10/20	?	?	?	17 600	79	2	0	18	Neu
26	?	?	?	16 200	62	1	0	37	"
2/5/20	30%	0.607	2,470,000	18,200	78	0	1	21	Neu
21	?	?	?	12 400	80	1	0	19	Neu
30	44%	0.7	3,200,000	32,800	91	0	3	16	Neu
5/12/20	58%	0.69	4,200,000	10,000	59	2	0	39	Neu

Miscellaneous Examinations

DATE	EXAMINATION OF	FOR	RESULT OF EXAMINATION
1/11/20	Feces	Blood, etc	Blood ++, Tubercle bacilli not found
2/19/20	Blood	Wass R. + S. C. F.	Wass. R.-Neg Gonococcus R-Neg
27	Neural Fluid	General	Cl. yel., Lenko ++, T.B. etc not found
27	"	Wass R	Wass R-Neg S C F - Neg
3/5/20	Pus-Infiltrated	Bacteria	Coccal streptococci - no T.B. found
31	Pus-Stomach	Bacteria	Med. + streptococci - attenuated in organ
5/13/20	Pus-Sweat	Bacteria	Direct exam. - Neg Culture - a staphylo extremus

NOTE: Where in doubt of results under Miscellaneous Heading, either consult physician before charting or refer to the original report.

Fig. 7.

The last form of this series is a "Laboratory Chart" (Fig. 7) which forms part of every bedside chart. It provides for the name, the ward and the admission and discharge numbers. The admission and discharge numbers are filled in only when one of the forms is used to provide a summary of the laboratory examinations for another institution or for a physician. Space is then provided to note the most important factors from fifteen urine examinations. Topics are provided as follows: date, specific gravity, volume, reaction, albumen, sugar, bile, acetone, two blanks, hyaline casts, granular casts, pus, blood, and one more blank.

Then a block provides for six blood counts, providing for the date, hemoglobin per cent (% Hgbl.), index, red cells, white cells, polynuclears, i. e., neutrophils. (neutro) and eosinophils (eosin.), mononuclear leucocytes (monoleucos.), lympho-

cytes. Ruled blank columns, three small and one large, are also provided. Then there is a block for nine "Miscellaneous Examinations." The topics are the "date", "examination of" "for" and "results of examination." This block is followed by "Note: Where in doubt of results under Miscellaneous heading, either consult physician before charting or refer to the original report."

This form provides sufficient space to summarize the results of all laboratory examinations on practically all cases. It is figured for a two-week period. Should more examinations be made another one of these charts can be attached to the history. This chart aims to conveniently visualize the progress of the case. Being a part of the standard chart this form is white.

These forms are of different colors to show at a glance which case has had laboratory assistance beyond a routine urine examination and the type of examinations that were made. The colors should be such as contrast well the typed or written data. All lines being aids to the eye only should not be too heavy. A light green is used across the sheets for ordinary spacing and a light pink for blocking where lines and blocks are advisable.

HOSPITALS AS CHARITABLE INSTITUTIONS

The right of the hospital to seek public support is well put in a letter from the architect, F. H. Ellerbe of St. Paul, which is published in the annual report of St. Mary's Hospital at Duluth, Minn. Mr. Ellerbe planned the new wing of St. Mary's Hospital which is now under construction. His letter follows:

"There has always been a question in the mind of the public as to whether or not a hospital which demands or accepts pay for its services can properly be classed as a charitable institution, and thus be entitled to share in funds that are raised for charitable purposes.

"Inasmuch as no two hospitals operate under exactly similar conditions, it would obviously be impossible to class them all alike in this respect, but with the exception of a comparatively few strictly private institutions practically all hospitals are expected to, and actually do, furnish a great amount of service either entirely free or at much less than actual cost.

"It is now generally conceded that a hospital operated for charitable patients only is not altogether desirable. Many considerations lead to this conclusion, principal among which is the difficulty of securing proper medical attention and suitable facilities for diagnosis and treatment. The hospital which is caring for private cases must provide facilities and it attracts the best men to its staff. The eminent men have always been willing to devote a reasonable amount of time to charitable cases, and it is quite apparent that the limited amount of time which they can be expected to devote to such work can be employed more effectively if the charitable patients are accommodated in the same building with the pay patients, where the physician can attend them without loss of time and where they can have the advantages of the expensive facilities provided for the pay patients. Therefore, the fact that a hospital is receiving pay patients does not, and should not, remove it from the class of charitable institutions.

"Moreover, there is a large class of people who require hospital service and who are willing and able to pay a limited amount, but not enough to cover its actual cost, to say nothing of a profit, and such service is as much of a charity in kind, if not in degree, as that for which no charge is made. There can be no doubt but that the public appreciates this fact. The fact which it does not appreciate and which leads to the misconception in regard to this kind of service and raises the question above referred to in the mind of the public is the cost of hospital services. Most hospital rates were fixed years ago when prices were comparatively low and where there has been any advance in recent years, it has been moderate in comparison with the increased operating cost, which during the past few years has amounted to at least 70 per cent. This estimate is conservative, for most of the larger items entering into the calculation, such as labor, fuel, chemicals, food, linen, glassware, etc., have increased from 100 to several hundred per cent. Even the old rates for ward beds were considerably below cost, which fact can be readily appreciated if a comparison is made between them and the hotel rates which prevailed at that time. The hospital rate was almost invariably lower than those of the hotel operating upon the American plan, while the hospital service was very much more expensive than the hotel service. In a hotel the guest does not receive any personal attention that he does not pay extra for, and his meals are served in the dining room. In the hospital the patient receives a large amount of personal attention and a majority of his meals are served in his room. In the American hotel, no special meals are served; in the hospital a large number of special meals are prepared every day. In the hotel of moderate size the personnel (staff and employes) will average one or less to each five guests; in the hospital of moderate size the personnel will average one or more to each patient. The hotel has many other sources of revenue; the hospital has none except what is received directly from the patient. The operating cost of a hotel has advanced in about the same proportion as that of a hospital, but their rates have been advanced in approximately the same proportion and it is doubtful if they will ever get back to a pre-war basis. A prominent hotel operator recently admitted in an article in the Literary Digest that many hotels, prior to the prohibition act, would have been operating at a loss had it not been for their revenue from the sale of liquor.

"If the hospital was expected to have the same earning capacity, it would be necessary for it to charge rates at least twenty-five per cent higher than those of a corresponding hotel, and the comparison would usually have to be made with a first class hotel occupying a fireproof and expensively furnished building. Even to pay expenses the hospital would have to charge as much as the average first class hotel, but, as a matter of fact, hospitals do not and cannot charge such rates except to private patients of the well-to-do class and consequently an operating deficit is created. This deficit can sometimes be partly absorbed by the profit made from the comparatively few well-to-do private patients who can afford to pay a rate which will result in a profit. This profit is, however, seldom sufficient to make up the entire deficit and is never sufficient both to meet the deficit and provide for necessary replacements and extensions. Therefore, the hospital which is accepting any considerable number of free cases and patients who do not pay full rates is unquestionably entitled to a full share of public support and the friends of such hospitals can, with the utmost propriety, demand their recognition as charitable institutions."

The MODERN HOSPITAL

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SEPTEMBER 25-28

IF PRESENT plans mature, the exposition of equipment and supplies will more nearly take its rightful place at the forthcoming meeting of the American Hospital Association than in any previous year. A renewed effort will be made this year to break away completely from the deadly practice of having delegates listen hour after hour for four successive days to formal paper after formal paper. Last year's effort in this direction was only partially successful.

The exposition, to be sure, has always been regarded as an integral part of the convention. The practice hitherto, however, has been to keep it more or less in a watertight compartment. Its existence was routinely announced from the platform and delegates were urged to study it. But such was the crowded condition of the program that delegates found it exceedingly difficult to follow the suggestion. It meant either the neglect of some important meeting or a hurried visit in the late afternoon or after the evening sessions.

This year there is to be a fairly radical change for the better. Not only does the conference program set aside definite periods of time for the study of the exposition, but early sessions of the conference will be devoted largely to the reports of special exposition committees. To these committees have been assigned the important duties of examining the exposition critically and reporting what may be learned by delegates and the best way for them to learn it. Furthermore, it will be the duty of these committees to acquaint delegates with the best hospital practices pertaining to the sections of the exposition they are asked to cover. This is an admirable plan and should enable delegates to get the most out of the exposition with the least expenditure of time and effort.

During the past year the association has had five or six special committees actively at work seeking solutions to some of the hospital's most trying problems. These committees will submit their reports at the conference. They will deal with gauze renovations and standardized dressings; hospital floors; forms and records, with particular reference to the annual report; the relation between hospitals and the states and cities in which they are located; and training for hospital social work.

The conference will be enriched by concurrent meetings of allied national bodies dealing with certain phases of hospital work. These will include the American Association of Hospital Social Workers, The American Occupational Therapy Association and the Protestant Hospital Association.

One of the new features which will undoubtedly prove stimulating will be the organized visits of delegates to some of the hospitals in New York and Philadelphia. The special features of these hospitals will be emphasized and illuminating demonstrations given.

All in all the Atlantic City convention promises to be one of the most helpful of recent years, and trustees should see that the superintendents of their institutions attend. With the inauguration last year of a trustee section, trustees themselves will find attendance upon the convention eminently worth their while.

THE DISPENSARY PROGRESSES

IN ITS issue of August 5 the *Journal of the American Medical Association* presents the first of a series of articles relative to the statistical data on dispensaries collected by the council of medical education and hospitals of the American Medical Association. This article is devoted to a presentation of the data pertaining only to general dispensaries; later articles will deal with special dispensaries and clinics, such as tuberculosis, mental hygiene, venereal disease, baby and child hygiene, and eye, ear, nose and throat dispensaries, together with industrial dis-

pensaries and clinics devoted to group practice.

It is interesting to note that whereas in 1916 Davis and Warner in their book on dispensaries place the number of these institutions at 900, this survey gives definite information in regard to 3,243 dispensaries, and its authors believe there is authoritative evidence enough to hazard the statement that there are a total of at least 4,000 dispensaries in the United States.

Consideration of the figures gathered gives one some conception of the stupendous amount of work done in these institutions. The 946 general dispensaries from which reports were received handled 3,872,345 patients during the last fiscal year. They made 11,789,887 visits. Including a reasonable estimate for the dispensaries that did not report, the authors believe these figures would be increased to 4,250,000 patients and 13,500,000 visits. These figures are quite exclusive of the special dispensaries and clinics which cared for 3,750,000 patients during the year, who in that time made 16,000,000 visits, bringing the grand total up to 8,000,000 patients who made 29,500,000 visits. The article calls attention, however, to the fact that the number of separate individuals who use the dispensaries and clinics is somewhat less than 8,000,000 since allowances must be made for those who visited two or more institutions during the year.

The tables included in the article give the distribution of general dispensaries by states, the number and work of the general dispensaries in the fifty largest cities; the number of physicians serving in general dispensaries, whether on full or part time; the types of teaching carried on in general dispensaries; the out-patient service in hospitals approved for internships; the financial support of general dispensaries; and the number of social workers employed in general dispensaries, whether paid or volunteer. These tables warrant careful study. Some of the main facts brought out by the survey are:

1. There is a steady increase in the number of patients seeking treatment in general dispensaries.

2. There has been an unprecedented increase since the war in the number of special clinics and dispensaries, such as those for tuberculosis, venereal disease, mental hygiene and child hygiene.

3. There is great need for individualized study and treatment of dispensary patients, to counteract what seems to be a prevailing tendency to routinization.

4. There is need of a closer bond between the out-patient service and the other service of hospitals, and this will best be met by having the hospital and the out-patient staffs identical and by keeping unified records.

5. In the matter of finances there is an increasing tendency to charge nominal fees, thereby placing part of the cost of an institution on the patient.

6. A general increase is noted in the use of social service workers to see that patients continue their treatment, and to investigate their social and financial status so as to prevent pauperizing.

7. The difficulty of securing satisfactory data is increased by the inadequacy of clinical and office record systems in a large number of institutions.

8. There is a great and increasing amount of educational work, especially the teachings of interns, medical students, graduates and pupil nurses.

Commenting on the almost unbelievable increase in the number of dispensaries established during the last decade, the *Journal of the American Medical Association* observes that "the increase in population in the country has had some influence on the development of out-patient dispensaries, but the chief stimulus, especially in recent years, has been the increasing popularity of the dispensary as a place to secure satisfactory medical service. It has been during recent years also that dispensaries have established well-organized medical staffs and have required their prompt and regular attendance. In addition to this, there has been an increasing tendency toward the establishment of graduated scales of fees by which those who were unwilling to accept charity at the free dispensaries are more willing to patronize the institutions. Another influence leading to the increase in numbers is the recognition by hospitals of the importance of out-patient departments as a means of better serving the people in their communities. It is found that many hospital patients during convalescence can secure the necessary follow-up treatment as ambulatory patients of the out-patient departments."

But whatever the causes for this remarkable increase in the number of dispensaries and the variety of their work may be, it is evident that the dispensary, the potentialities of which have hitherto been foolishly ignored, is fast taking the place in our medical economy that it deservedly should.

SAFETY CORPS

IN HIS article on "Hospital Signal Systems" on page 247 of the current issue Mr. E. Newton-Wells makes a recommendation that should be acted upon more generally by hospitals. He recommends that in every hospital there be or-

ganized a safety corps whose duty it will be, in the event of fire, to meet upon signal at a given point and if possible extinguish the blaze or assist in moving patients to points of safety. Our attention has been called to a number of instances of incipient fires which have been extinguished by safety corps so quickly and quietly that even the patients in nearby rooms knew nothing of the danger. They have often thwarted what might easily have developed into a holocaust.

The organization of safety corps is so simple a procedure and the work they may do at a critical moment so vital that it is difficult to conceive of a hospital without one. However fire-resisting or fireproof a hospital may be, it is not, as Mr. Wells pertinently points out, free from fire risks due to panic, smoke, etc. Safety corps can do much to minimize the risks if not avert them altogether.

PRICE NOT THE ONLY CRITERION

THE unprejudiced mind, we feel confident, will gladly concede that the hospital should use only high grades of supplies, especially medical supplies. And yet word comes to us every now and again of hospitals that buy their supplies solely on the basis of price with a total disregard of the factor of quality. Take alcohol as an example. Comparatively speaking the consumption of alcohol in the hospital is not very great and the total expense for this commodity would be relatively small even if the best quality were purchased. Nevertheless, not a few hospitals in making up their medicinal compounds and even in the sterilizing of their surgical instruments are using an inferior grade of alcohol which in the long run is bound to be reflected in the quality of the institution's service.

Not even in the selection of preparations used for rubbing and bathing its patients can the hospitals be indifferent. The highest grades of preparations used for this purpose are the result of intensive study by technically trained men, so that the finished product is compounded of ingredients which have been chosen because of some specifically beneficial action.

Still many hospitals, taking price as their only criterion, do not hesitate to purchase preparations to the production of which only a modicum of study and experiment has been given.

Hospital superintendents should awake to the dangers of this tendency to disregard quality in the interests of price; not the least of these is the danger that manufacturers who would be ashamed to furnish hospitals with other than first grade medical supplies will discontinue their activities in this field.

FIRE LAWS FOR HOSPITALS

DURING its recent annual meeting at Atlantic City the National Fire Protection Association adopted a series of twelve resolutions advocating certain measures in its warfare against the needless sacrifice of human life and property by fire. Among these resolutions were two advocating the adoption by municipalities of the standard building code of the National Board of Fire Underwriters to the end that fire-resistive building construction may be encouraged, the use of inflammable roof coverings prohibited, adequate exit facilities from buildings assured and interiors so designed and fire-stopped as to prevent or materially retard the development and spread of fire therein, and the adoption by all states and provinces of minimum building requirements for the protection of public and private hospitals, schools, asylums and similar institutions.

Nowhere is protection from fire more imperative than in hospitals and kindred buildings where thousands of more or less helpless, bed-ridden patients are housed. These resolutions point the way to a more adequate protection, particularly of human life, and all interested in efficient hospital administration should use their influence persistently in seeing that these resolutions are acted upon by the responsible municipal, state and provincial authorities. Delay in a matter of such vital importance is a breach of public trust that is little short of criminal.

SYSTEM IN THE SORTING ROOM

THE sorting of the hospital's laundry after it has been washed looks like a simple process. Yet have you ever spent a half hour in the sorting room of the laundry of a hospital in which the marking and folding of garments are left to personal whim or chance, instead of being controlled by a definite system? We have. And as we have watched the sorters fumble the garments in their efforts to find the laundry marks, we have been amazed at the amount of time and effort they wasted. Unguided by any system, the sorters, instead of looking in one place, often looked in three or four before the marks were finally found. Here surely is a fruitful field for the application of the adage, "A place for everything and everything in its place." In a series of three articles, beginning in this issue, Mr. Walter T. Williams deals in some detail with this subject. Some hospitals will doubtless wish to adopt the system of marking and folding he presents; but, whether his system is adopted or not, every hospital should establish some definite scheme for sorting its laundry expeditiously.

ESTABLISHING A NEW RECORD FOR HOSPITAL ENTERPRISE IN NEW ENGLAND

By GEORGE W. GARDINER, Chairman, Campaign Executive Committee, Homeopathic Hospital, Providence, R. I.

DURING the week, May 7-15, Providence conducted a campaign to build, equip and endow a new home for the Homeopathic Hospital of Rhode Island in that city. The objective was $1,000,000. The subscriptions by the close of the campaign, Monday evening, May 15, amounted to $1,222,608, more than twenty-two per cent in excess of the goal.

This campaign was remarkable in many respects. In the first place, the fund subscribed is the largest on record for a single hospital enterprise undertaken and completed at one time anywhere in New England. It was much the largest civic project ever attempted in the city of Providence and by far the most successful.

There were eighty teams of workers, comprising more than 800 men and women, and they were given access to a list of more than 32,000 carefully selected prospects. The workers went over the lists persistently, selecting the subscribers they preferred to see, and in this way they rolled up a total of about 6,500 subscriptions. The average subscription was therefore $188. Taking the population of Providence at 240,000, the fund subscribed is equivalent to over $5 per capita.

Thirty-Bed Hospital Expands to 250 Beds

One of the outstanding features of the campaign was the fact that the present Homeopathic Hospital, which is to be replaced by the new structure, is a small hospital with a capacity of thirty beds and having a value of about $30,000, whereas the new hospital that is now to be built will have a capacity of 250 beds and will be located upon a particularly well-chosen hospital site of eight acres for which the trustees paid $25,000 five years ago. In other words, the campaign actually called for, not so much an enlargement of or an addition to the existing hospital, as the creation at a single stroke of a complete new hospital of almost nine times the capacity of the old one.

Local papers gave much valuable publicity.

Those who took part in the campaign ascribed its conspicuous success to the thoroughness of the preparation, the forceful appeal made through publicity of a carefully conservative and soberly reasoned character, and a complete disciplined and enthusiastic organization of the working force.

The case for the new Homeopathic Hospital of Rhode Island was clear cut. In the publicity, facts, and yet more facts, were insistently presented. These showed how seriously the city was under-equipped in hospital facilities. A comparative table was used in the advertising and in the campaign literature which showed that among eight cities with which Providence might reasonably be compared, Providence stood last.

A persuasive appeal was based upon the fact that the Homeopathic Hospital of Rhode Island is an "open" hospital, where physicians of the old school as well as physicians of the new school may hospitalize their patients. It is the only hospital in the state which affords this privilege to physicians of the homeopathic school.

The policy of the hospital with respect to free service was effective in the campaign. The hospital was established in 1904, particularly for the benefit of the poor, and it has always given a large measure of free service. During the campaign it was announced that in the new hospital 122 beds will be free beds. The reputation of the hospital for medical and surgical treatment has been unquestioned.

Cartoons in Providence dailies helped the drive.

There were difficulties in the way. Coincidently with the campaign of the Homeopathic Hospital other hospitals in the city were in need of funds and were planning campaigns. Business conditions were untoward, particularly because of the stagnation in the cotton mills through the Blackstone and Pawtuxet Valleys during a strike which had continued for seventeen weeks when the campaign closed.

Then, too, the city had never tackled so large a job in a civic way. Hundreds of those who were members of the campaign working force had never shared in a similar enterprise, and thousands of those who contributed had never participated in a hospital fund before.

Just before the campaign closed and while the final figures therefore were in doubt, Col. Webster Knight, president of the hospital, made the following public statement, which expresses a view that later became the general public verdict concerning the campaign:

"This is a wonderful thing that the workers for the new hospital have done. In four days' time, through an organization brought together for civic service, they have already rolled up a total of pledges greater than ever before gathered for a single civic enterprise here.

"They have tested and accepted the facts. They have recognized the need. They have volunteered their service, and they have gone out with disciplined enthusiasm in order to give their city larger hospital facilities.

"And they are getting what they went after. To have received from thousands of subscribers pledges of more than half a million dollars is in itself a splendid piece of work. But the increases in the amounts reported from day to day are perhaps even more remarkable. On the first day—which was, indeed, but half a working day—they brought in $16,500. On the fourth day they brought in $107,000.

"Such figures, however regarded, are amazing. They are a magnificent proof of the public spirit and the civil loyalty of the people of Providence, and they are an evidence of far more than mere money values. They mark the rise of a high tide of social endeavor for the common good which promises well for the future.

"This organization is largely composed of men and women who never before have teamed together for such a project as this. As a constructive body, working in concert, they are a new force in the democracy of our city. Their achievement is opening new doors of opportunity, new prospects of civic advance.

"Deeply as I rejoice because the good work of this organization in assuring the new hospital, I am scarcely less gratified at the thought that, through the activity of this fresh vital force, all Providence is awake to a new sense of self-reliance and power. What our citizens have done and will do for the new hospital is a pledge of what they can do in any other field when their minds are in full accord and their hearts are in unison.

"If the movement for the new hospital had created only this inspiring example of cooperation for civic betterment, it would be worth all the effort that has gone into it. We of Providence have found within ourselves unlimited resources of service and achievement.

"In gaining the new hospital, our people will win for themselves a richer municipal life and a greater sense of power for all good uses. I look forward to Monday night with confidence and pride. All of us are enriched and uplifted because of the work we are doing together for our city, for ourselves and for those in need."

During the campaign much emphasis was laid upon the accessibility of the hospital site. The tract, which faces on Chalkstone Avenue, opposite Davis Park, is a converging center for three of the chief manufacturing districts of the city. It may be reached quickly by a direct route from the Union Station. Accident cases in the mills, as well as emergency cases coming to Providence from out of town by railway, may be taken to the hospital at an average saving of seven minutes as compared with the other Providence hospitals.

An event that attracted widespread attention was the ceremony of breaking ground for the new hospital, held on National Hospital Day, May 12, in the midst of the campaign week. The Governor of Rhode Island and the Mayor of Providence were among the speakers, and Col. Knight dug the first shovelful of earth. Hospital nurses, boy scouts and girl scouts, the campaign executive committee and hundreds of spectators attended the exercises.

THE STATUS OF THE NURSING ATTENDANT*

By A. K. HAYWOOD, M.D., Superintendent, The Montreal General Hospital, Montreal, Quebec.

THE misgivings that naturally come over one when dealing with an experiment were experienced by me when I accepted the invitation to speak to you this evening. The attendant's course which you have just completed and from which you are now being graduated, while not an experiment in the true sense of the word, is an experiment in this city and province.

The trained attendant first made her appearance in Boston in 1912 through the Household Nursing Association, but it was not until 1918 that a definite course of training was established and since that time several schools for trained attendants have been founded in Canada and the United States.

Innovations Bring Criticism

You are no doubt aware that the course which you have just completed is open to criticism, but it is mainly the criticism that one finds directed against any new project or innovation that tends to deviate from tradition or long established custom.

It is quite unlikely that these schools for attendants would have been established had there not been a demand for the class of service that you have been trained to render. This demand is urgent at the present time, and I have no doubt that you will find plenty of opportunities to practice your calling in this city, and it is in view of this probability that I would sound a note of warning.

A knowledge of the needs of this community convinces one that there are scores of families who, when illness overtakes them, will find in your services a blessing. I do not wish to intimate that you will be sufficiently versed in the art of nursing to take the place of the graduate nurse. Her position and knowledge are only made possible after three years of the hardest kind of work, study and sacrifice, and it is only natural that she will view graduation exercises as you have them this evening with apprehension; but I feel sure that the graduate nurse will realize in time that it is possible for her work to be supplemented by a body of women such as you represent. One cannot help but feel that in many cases of chronic illness, in convalescence, and in caring for children, the employment of a graduate nurse would tend to produce such financial embarrassment in that family that would make her employment impossible, nor is it right that on this account some form of service should not be available for this class of patient.

You are not nurses and my kindest advice to you is to recognize and remember that fact at all times. The nursing profession is an old one and has progressed and perfected itself by many trials and tribulations. Nurses have every just and sufficient reason to be proud and jealous of their prerogatives, and while it is my sincere wish that you should meet with every success in your limited field I hasten to warn you to avoid the paths of criticism.

Your course is still in its infancy. I understand that you are the second class to graduate, and to you is entrusted a great deal of the future success of this venture. You can rest assured that you will be watched with a great deal of interest, and there is no doubt that your mistakes and shortcomings will be made capital of to the detriment of this cause.

Need Practical Hospital Training

This course which you have just taken will undergo many changes. I hope I will not be misjudged if I venture a few suggestions as to those changes that at the present time might be profitably adopted. I cannot help but feel that your usefulness would be materially increased had it been possible for you to have supplemented your theoretical work with practical work in institutions that lend themselves to your particular class of work. By that I mean institutions for incurables, convalescents, certain classes of children's hospitals, or even small general hospitals without training schools in which there is difficulty in securing probationers. The question is bound to be asked why not general hospitals with training schools? The answer is that experience has proved in those hospitals that have combined the attendants' course with the nurses' course that it has not been successful. The attendant has had relegated to her the most menial duties of the wards without the interesting nursing care to make this drudgery bearable. There is inevitable jealousy and friction between the two classes of pupils.

Your future as attendants and your proper employment are largely in the hands of physicians, and I sincerely trust that the physicians that employ you will insist on continued supervision of your work, and by that supervision you will avoid the pitfalls that await you which if not avoided will bring your entire organization into disrepute.

To those who have been instrumental in enabling you to take this course, great credit is due. The Y. W. C. A. in fostering this work has done the community a real service. Whether you young ladies have undertaken this work as a means of livelihood or better to fit themselves for your home duties in case of illness matters not when

*An address to graduates of the second Attendants' Course given by the Y. W. C. A. in Montreal.

one realizes the lack of knowledge of the first principles of home nursing so prevalent in the young woman of today. One cannot but feel sorry at the young wife's apparent confusion when asked by her physician if she has taken a temperature, or at her lack of knowledge of the first principles of hygiene.

Urges Legislation Against Unscrupulous

I am sure that those who are fostering this cause have no intention, in giving recognition to the trained attendant, to provide a poorly trained nurse for the poor or middle class, and my last word of warning is to prepare now for legislation that will make it just as impossible for an unscrupulous attendant to practice as a nurse, as it is now impossible for a nurse to practice as a physician.

The community needs your services badly, and I hope that your course will be broadened and developed with a sincere view to a large community service. Our hospitals are now overcrowded, and we are told that only ten per cent of the sick of the community are in the hospital so you can see what a broad field is open to you.

In closing I would like to quote from an article that I came across in a recent number of the *British Journal of Nursing*—"We fear that the short term training of nurse attendants in Canada and the United States, who are "registered," is going to undercut standards and fees for genuine professional nurses. When the arrangement was agreed we felt sure that the profession was trifling with its economic stability. We note from our press cuttings from abroad that these 'attendants' have assumed the complete white uniform of the professional nurse. The Y. W. C. A. is responsible for turning out those graduates in Montreal, but we are told their training is not considered complete until they have been in attendance upon a certain number of patients. Let us hope such patients are not charged for trained services."

I read this quotation without passing any further comment. It senses certain fears of the nursing profession, but I am convinced that your organization is aware of these fears and will avoid them, and by so doing will command the respect and assistance not only of the nursing profession itself but of all others who have the interest of the community at heart.

PROFESSIONAL RECORDS FOR THE HOSPITAL*

PRECEDING papers in this series, supplementing and interpreting the report of the Committee on Hospital Forms and Records, discussed Divisions A, B and C of the report pertaining to the records used in accounting, purchase and issuance, administrative functions and to the necessity of providing a routine and ready method for the study and analysis of the institution's activities.

The remaining divisions of the report, D, E, F and G, pertain to the records of professional services, including clinical records, records of the school for nurses, social service and out-patient or dispensary service. The records used in these divisions will probably require less interpretation because they are more or less self-explanatory.

Patients' History

The reasons for keeping clinical records may be briefly summarized as follows:

1. To show at any later date an accurate record of the professional measures instituted in any given case.
2. To provide a basis for the analysis of the work of attending physicians and surgeons.
3. To provide a basis for research and study in medical practice.
4. To provide a means of instructing medical students in the proper method of making a diagnosis.
5. To provide the attending staff with a written record of the patient's progress.
6. To enable the hospital to fulfill its obligation to the patient in providing such record upon request.
7. To provide a basis for legal evidence if needed.
8. To stimulate adequate and competent service on the part of the attending physician and surgeons.

Numerous other reasons may be cited. The preparation and maintenance of a careful clinical history will serve as a definite stimulus to more accurate diagnosis and service by the attending physician.

Many of the forms submitted to the committee seemed to indicate that the making of the clinical record in some institutions is an intricate, cumbersome and time-consuming process, because of the many elaborate and specialized forms in use.

It is our belief that while the records should be adequate and complete, they should remain simple in form and permit the exercise of initiative and of freedom of expression on the part of physician and nurse.

Under Division D, subdivisions D-1-A to D-1-L, we believe are listed those forms essential in any clinical record. The forms submitted were of simple outline. All printed instructions to physicians and nurses were avoided, in the interest of economy.

There are many who prefer a definite printed outline to be completed by checks and affirmative or negative answers. Such records may well serve in individual instances, but as the outline used differs very materially the committee could not endeavor to select or recommend any particular form. It was therefore recommended that for the sake of uniformity in hospital practice, the plain and simple form be used. Emphasis however must be placed upon the necessity of adopting in each institution a definite procedure and system of history-taking; the attending staff should then be held responsible for the continued use of that system.

Because of the great number and variety of special forms in use and the cost of such forms, a warning was voiced in the report that special forms should only be adopted after careful consideration.

Attention is called to the fact that we are accumulating a vast volume of clinical records in the hospitals of this country and in Canada. This recorded experience of present-day methods in the practice of medicine is serving in a very meager and almost wholly local manner in improving methods of diagnosis and treatment. Some national mechanism is needed, whereby the information being collected may be analyzed and published for the benefit of the entire medical profession.

Under this heading, Division E of the report, seven forms were included. All are self explanatory and follow

*This article, prepared by A. C. Bachmeyer, M.D., F. E. Chapman and John Bresnahan, M.D., is the fourth and last of a series interpreting the report of the committee on forms and records which was made at the twenty-third annual meeting of the American Hospital Association in September, 1921.

for the most part recommendations previously made in other conventions.

The records necessary, in this instance, pertain to:

Information for the prospective student concerning the individual school. This is usually presented in the form of an announcement or catalogue. No recommendation concerning such announcement was made.

Information concerning the applicant. Such information can be secured in a definite way, by means of an application blank, previous school record, reference forms and physician's examination forms. Samples of these accompanied the report.

Information concerning the student while in the school. This information collected from instructors' and supervisors' reports can easily be noted upon definite record forms, samples of which were submitted.

All information should then be filed in an envelope so that at any time complete records of any nurse student can be obtained by referring to her individual file. If all correspondence concerning the student is likewise filed in the same envelope, it will prove a quick and ready reference in all instances.

Social Service

The opinion of the committee on social service records was voiced in the following paragraph of the report:

"A social history, name and family index card, with the addition of a follow-up tickler, would in all probability suffice as record forms for this department. The tendency to develop a heavy overhead of clerical work should be discouraged, and the workers left free to accomplish their purpose in the field. It is recommended that the above named forms, with a system of filing duplicates of social history under a 'social diagnosis classification' and the use of such files for statistical purposes at the close of any given period, be adopted."

Four forms were included under this heading and it is believed that they will suffice to give adequate records. We desire to call attention to the desirability of filing the social history with the medical history of the patient, in order that all information pertaining to the patient may be in one place and readily available for reference. Such practice will also bring the social facts of the case to the attention of the physician and serve to stimulate his interest in that phase of his patient's difficulty. Thus the physician's cooperation with the social service department will be promoted.

Out-Patient Department

The same fundamental principles that apply to the administration of a hospital proper are applicable to the dispensary or out-patient service.

The distribution of operating income and expense can be made in a similar manner to that of the hospital. Per capita cost should be determined upon a "per visit basis." Dispensary income and expense should be kept separate and not included in the same totals as that of the hospital proper, though they may readily be carried in the same books.

The specific data required in the dispensary comprise information concerning the admission and assignment of the patient, clinical record, social service record, discharge and follow-up record and instructions to the patient concerning return or re-visit.

A few of these special forms were submitted with the report. It was recommended that the same principles be followed here as in the hospital proper.

It is essential for efficiency of operation and control that the clinical records of the out-patient department and of the hospital be intimately related. The ideal system would be one in which the records were identical and followed the patient from the dispensary to the hospital or vice versa. Frequent handling of records in the out-patient department requires usually a tougher grade of paper to withstand the wear and tear than is necessary in hospital records. A central filing room for both sets of records is a definite advantage. If the same record sheets cannot be used in both instances a system of abstracting the records of one department for use in the other should be established.

In conclusion, the committee desires to express its appreciation of the manner in which the work thus far done has been received. It recognizes that the recommendations and sample forms submitted will not without modifications apply in all instances. It is not intended that each hospital shall use every form mentioned in the report; a number of them will be found superfluous in many instances, and in many institutions additional records will be necessary.

We believe however that if the principles enumerated in the report are accepted and followed and if in general this scheme of record keeping is adopted, it will, through uniformity of practice, be productive of great good in the hospitals of the country.

By means of the use of some such system as this, plus the filing of annual reports with some central agency, such as the Hospital Library and Service Bureau where statistics might be compiled and published, there is an opportunity to prepare statistics that will be of great value and of assistance to each hospital administrator.

PAYMENT OF HOSPITAL ACCOUNTS

The time to make arrangements regarding the settlement of private accounts is when the patient is admitted, according to O. J. Decker, superintendent of the Toronto (Ont.) General Hospital. The rate of the room, operating room fees, special nurses' board, etc., should be clearly explained. If the patient is unable to pay at the time he is admitted, or not able to pay at all, there is nothing humiliating in saying so. There is no resentment from a frank business talk with a patient when he comes into the hospital. If the patient is too ill when admitted to the hospital to be questioned, then these questions must be discussed with the friend or relative accompanying him. Nine times out of ten in private cases someone will accompany the patient. One week's maintenance should be deposited in advance by every private patient admitted to the hospital. During the patient's stay the accounts should be rendered and sent to the patient on the day that the deposit, which was originally made, becomes exhausted. If a further payment is not made within a week, the patient's friends or relatives should be notified that in accordance with the rules of the hospital the patient will be transferred to a free bed unless settlement of the account is made immediately. Some may think that this is rather harsh treatment. It may be considered so in the beginning, but it is only a matter of a short time until the hospital's policy will become known to the community and you will have very little difficulty with your private accounts.

"To some of us the greatest miracle, repeated every day, is that we can live at all in surroundings which our ignorance and neglect create."—Florence Nightingale.

"Our grand business is not to see what lies dimly at a distance, but to do what lies clearly close at hand."—Carlyle.

READING—A DOCTOR'S PRESCRIPTION IN THE HOSPITALS OF ST. PAUL

ALONG the trail blazed by the public library of Sioux City, Iowa, in supplying a steady and ever-lengthening line, Lakeside Hospital at Cleveland, a large Toledo institution, the Mayos at Rochester and many more are installing circulating libraries.

Among the pioneers in this field, which is new in civilian life but tested in war, the Public Library of St. Paul claims second place. Modelling its service after the Sioux City group system and enlarging and adapting it to fit local conditions, the hospital extension work of the St. Paul library has been functioning actively since March.

Miss Perrie Jones, hospital librarian at St. Paul, writes both helpfully and entertainingly of the early struggles and achievements of library service in the hospitals of that city and by frequent intimate flashes of dialogue and description shows what a boon reading may be to patient, doctor and nurse. Following are excerpts from Miss Jones' reports to the Amherst H. Wilder board of the hospital service of the St. Paul library:

Taking medicine from books at a St. Paul hospital.

"With 2,000 hospital sick in the city the question first off was: What should be the source of the 3,000 or 4,000 books from which the patients must draw? To take that number directly out of circulation from the public library would cripple very decidedly the service being rendered the community. So to avoid robbing Peter to pay Paul, we decided upon a book week. These six days, February 14-19, we advertised through the press, pulpit, by means of various publicity 'stunts,' and by direct appeal through clubs and meetings. The result was more than 4,000 books, about 3,000 of which were bedside material.

"As far as we could see there was only one fly in the ointment and that was the matter of carts to take the books from ward to ward and from bed to bed. Of course the whole value of this work rests not upon *books* in hospitals (that has existed for years), but upon *reading* in hospitals which is only possible through personal distribution of books. We needed ten carts and for a time advanced no farther than to the point of estimates, blue prints, hearings, committee meetings, personal interviews and expressions of interest and sympathy.

"In April the city council honored our requistion for seven carts, two were donated by individuals, and the tenth was procured by Maj. Gardner for Public Health Service Hospital No. 65 from the War Department. That takes care of all the hospitals and greatly facilitates the work.

"It is a matter of growing satisfaction to see the interest the doctors are taking in this matter of reading for the sick. The first day at M. P. Hospital I was stopped any number of times by attending physicians who wanted to know what it was, this traveling library. Without exception they expressed enthusiasm for the idea.

"Of course, it is medicine for them, the best kind of thing. 'Why hasn't it been done long ago?' was a general question.

"After it had been started it seemed such an obvious thing to do, of course. Here was a reading public of 2,000 who needed books and yearned for them, but who couldn't go where books were. With some, perhaps, it was their only opportunity to read.

"In any of the hospitals all it is necessary to show the book cart and the nurses come flocking.

"'Can you let me have this?—and this'? they ask.

"Others stop me with 'Don't forget 127' or '124 wants especially to see you.'

"We felt like journeymen tinkers dispensing our wares.

"At first they occasionally asked, 'Is there any charge'? Or as a lovely white-haired old lady from Sweden said, 'Hur kostet det?' When I said, 'Ingenting,' she answered with an eye to a bargain, 'Well then, I must certainly take it.'

"One powerfully built son of the North woods, with brooding eyes and the groping mentality of a child, as a result of a severe nervous breakdown, attracted my attention. The first time I saw him, feeling that there would not be much response, I simply said, 'Here is a good book for you,' and put it in his hands. 'L'right,' he growled, his frightened eyes following me suspiciously. The next time I found that he wanted above everything else a Buffalo Bill story. So I got it and now we have chats. He actually chuckles if the West is mentioned often enough.

"As a means of extending the library idea to the heterogeneous public I can think of no better agency than that of book service in the hospitals. We have daily evidence of its providing diversion and actual instruction for many who would otherwise live hour after hour with nothing to do but think of their miseries. One woman said to me, 'You know the last time you came in and left me a book, I didn't see what I could want of anything like that, I was in such pain. But I picked it up and actually could not put it down, and I forgot all about being ill.'

"That was what nice, amusing 'Martha-by-the-day' could do for one sufferer. A nerve patient in the same room took a book rather just because it was being done, as she assured me she had read practically everything in the library. She wanted something more, most decidedly, the next time the books came around. Can you think of what it must mean to a deaf and dumb patient to be supplied with books in the hospital? Such a case we found at St. Paul's the other day.

"Then of course, one often encounters the morose sick, usually a man, who more or less growls, 'Nope—never read.' Then, as he catches sight of the cart and books his curiosity is aroused. 'Well, what have you got?' he will ask, and very probably takes the first book he is shown. He settles himself back with 'Guess I might read that' with growing surprise at himself and things in general.

"There is a growing feeling, I think, that there is a very definite place in all hospitals for reading. It is not unusual now to have the floor nurse tell you, 'Dr. B—— wants you to get this patient of his to read if you can.' The doctors' orders now frequently contain a prescription for reading.

"Books are being given to the service regularly and the public shows a steady interest in the work not only by gifts of reading material but by requests for us to address clubs on the work.

"At the American Hospital Association convention at West Baden last autumn we were very cordially given space for any exhibit we might have and were sent the credentials of a full-fledged delegate. Unfortunately I could not leave but sent the exhibit consisting of posters, photographs and explanatory material. This I learned could not be exhibited inasmuch as no exhibit was shown without its sponsor on the ground. Another time some one must go and explain this phase of hospital work. It is a coming idea the arrival of which is not very far off."

ORGANIZATION OF McPHERSON COUNTY HOSPITAL*

By L. F. QUANTIUS, M.D., McPherson County Hospital, McPherson, Kansas.

THE organization of McPherson County Hospital was first made possible through the real fellowship of the physicians of McPherson which created a spirit of cooperation that the entire county was finally made to feel. This fact made it easier to present the matter of a county hospital to the citizens.

Our old hospital which was a stock organization had made an enviable record with the few conveniences it had. When the state legislature enacted a law permitting counties to build hospitals, each physician appointed himself a committee of one to present the matter to the the people. The Kansas law, which is given below, explains how it is possible to build and maintain a hospital and training school for nurses, with equal rights to all and privileges to none in a county of forty thousand or less.

"Any county having less than forty thousand inhabitants may establish a county hospital in the following manner: Whenever the board of commissioners of any county shall be presented with a petition, signed by twenty-five per cent of the resident free holders of such county, ten per cent of whom shall not be residents of the city, town or village, where it is proposed to locate such public hospital, asking that a tax may be levied for the establishment and maintenance of a public hospital at a place in the county named therein, and shall specify in the petition the maximum amount of money proposed to be expended in purchasing or building said hospital, such board of commissioners shall submit the question to the qualified electors of the county at the next general election to be held in the county or if no general election shall be held within six months from the date of the presentation of said petition, then at a special election called for that purpose, if requested in the petition, which tax shall not exceed two (2) mills on the dollar for any one year and be for the purchase of a site or sites and the erection thereon of a public hospital or hospital buildings, and for the support of the same: which said election shall be held at the usual places in such county for electing county officers, the vote to be canvassed in the same manner as that for county officers. The board of commissioners of such county shall submit to the qualified electors thereof, at a regular or special election, the question of whether there shall be levied upon the assessed property of such county a tax of ..... mills on the dollar for the purchase of real estate for hospital purposes, for the construction of hospital buildings and for maintaining same, or for either or all such purposes. The ballots to be used at an election at which the hospital question is submitted shall be printed with a statement substantially as follows: 'For a ..... mill tax for a public hospital and for the maintenance of same.' If a majority of the votes cast at such election on the proposition so submitted shall be in favor of a ..... mill tax for public hospital and for maintenance of the same, the board of commissioners shall levy the tax authorized, which shall be collected in the same manner as other taxes are collected and credited to the hospital fund, and shall be paid out on the order of the hospital trustees for the purpose authorized by this act and for no other purposes whatsoever.

"Appropriation for the improvement and maintenance in counties exercising the rights conferred by this act, the board of county commissioners is hereby authorized to levy a tax each year in addition to tax for hospital fund hereinbefore provided for, not to exceed one-half mill on the dollar, on all the taxable property of said county for the improvement and maintenance of any public hospital so established, such tax to be levied and collected as other taxes."

The $250,000 hospital built and operated by McPherson County, Kansas.

The advantages of a county hospital over a sectarian hospital are evident. When one is a patient in a de-

*Paper read before the last meeting of Kansas State Hospital Association.

nominational hospital, he is ever cognizant of the fact that he is receiving care through the kindness of some benevolent organization. Almost unconsciously the patient senses this. On the other hand the community or county hospital is the people's own institution and it has an atmosphere about it that bids one welcome.

We are accustomed to the practice of hospitals being built and equipped by cooperative interests. We know such institutions have filled a most needed place. Their contributions, however, are as nothing compared to the services which county hospitals may render.

When we launched our hospital project we first presented the situation to a sympathetic ear in each township and made sure that our township representative understood clearly the advantages of such an institution to the comunity. We also provided him with an influential citizen as a helper in securing the names of voters he was to interest. Our campaign thus begun was rushed to completion, and when the votes were counted, exclusive of those from the city of McPherson, there was a sufficient majority to carry the project.

The cost of our construction was $152,000. The equipment, which was the best we could obtain, cost $98,000, making a total of $250,000. The number of lives saved, based upon the commercial value of human lives, would already have almost paid for the institution, I am convinced. Although the above figures seem huge, communities should have the best equipment and laboratory facilities possible.

We have a fifty bed hospital with private rooms only, a toilet and lavatory to each room. The ground floor has a splendidly equipped kitchen, cold storage, laundry, water softener, storage rooms, nurses' cafeteria and dining room. The medical department is on the first floor, the obstetrical department on the second with the preparation room, birth room, and nursery; the surgical department on the third with two operating rooms, anesthetic room, sterilizing room, blanket warmer, physicians' dressing room equipped with shower, physicians' scrub-up room, nurses' scrub-up room, x-ray, bacteriological, pathological and chemical laboratories. Live steam is supplied to our sterilizer, blanket warmer, utility rooms, and main kitchen. Each floor has a large solarium on the south end of the building, and a diet kitchen and refrigerating plant are on each floor. The administrative part of the building, the kitchen and the laundry can readily take care of fifty more beds should the addition be required.

The fact that our hospital board is composed of laymen (physicians in active practice are prohibited from serving on the board) keeps the institution in the laymen's hands; for this policy the medical profession of our county is most grateful.

We feel we have hospital accommodations that would be impossible in a county of our population, under any other plan of building and maintenance, and that a fellowship is promoted among its physicians, that is of the greatest value to the community. Our men have an opportunity for special work along different lines making a more efficient hospital staff than is possible under the usual hospital management.

"'With God's blessing he will recover' is a common form of speech with people who, all the while, are neglecting the means on which God has made health or recovery to depend."—Florence Nightingale.

The vocation of every man and woman is to serve other people.—Tolstoi.

THEATER COMES TO PATIENTS

Because several hundred patients of a Los Angeles hospital could not go to the theater, the theater came to them. The occasion of the unusual *en masse* movement of a complete theatrical performance was July 4 which gave

Underwood and Underwood.
The hospital lawn's a stage.

promise of being a dreary affair for the shut-ins. The actors brought their entire show to the hospital lawn, and patients such as could be moved out of doors on wheel chairs, were able to watch the performance as well as the main floor of the theater.

DISINFECTION IN 1766

Dr. Thomas Bond in delivering one of his lectures to medical students on November 26, 1766 discussed current methods of disinfection and isolation as follows:

"I lately visited an Irish Passenger Vessel, which brought the People perfectly healthy untill they came in our River. I found five of them Ill, and others Unwell, & saw that the Fomes of infection was spreading among them. I therefore ordered the Ship to Lay at Quarantine, to be well purified with the Steams of Sulphur, & with Vinegar, directed the Bedding & Cloathing of the People to be well wash'd & Air'd, before any person should be permitted to Land out of her, after which I advised separating the Sick from the Healthy.

"This was done by putting twelve in different Rooms in one House, & fourteen in another, out of the City, the conveniences of the two Houses were much the same, in one of them little care was taken of the Sick, who were laid upon the same foul beds, they (contrary to orders) brought on Shore with them; the consequence was, that all the Family catch'd the distemper, & the Landlord Died. In the other my directions were Strictly observed, the Sick has clean Clothes, & clean Bedding, were well attended and soon Recovered, without doing the least injury to any person that visited them; which confirms my observations I had often made before, that the Contagion of the Malignant Fever lies in the Air confined & corrupted, by a neglect of Rags & other filth about the Helpless Sick, & not from their Bodies."

"Probably no person ever did that well which he did only for money. Certainly no person ever did that well which he did not work at as hard as if he did it solely for money. You never yet made an artist by paying him well. But—an artist ought to be well paid."—Florence Nightingale.

WHAT THE SMALL HOSPITAL PAYS ITS SUPERINTENDENTS

(Continued from page 209.)

No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase
28	F	150.00			
30	F	150.00	25.00		
*30	F	100.00	65.00		
*30	F	150.00	25.00	25.00	Jan., 1922
30	F	150.00	40.00	16.66	Jan., 1921
†30	F	100.00	40.00	12.00	1920
30	F	100.00	50.00		
30	F	125.00	56.00		
30	F	100.00	25.00	Reduced $50	
30	F	150.00	50.00		
30	F	100.00		25.00	June, 1919
30	F	130.00		10.00	Jan., 1922
*30	F	150.00	25.00	25.00	Jan., 1922
30	F	90.00	25.00		
30	F	150.00	40.00	25.00	1920
30	F	100.00	35.00	25.00	1919
30	F	125.00	35.00	25.00	Sept., 1921
30	F	150.00	18.00		
30	F	100.00	40.00		
30	F	150.00	50.00	25.00	June, 1920
†30	F	100.00	10.00	25.00	Jan., 1922
†30	F	200.00		50.00	Jan., 1920
*30	F	300.00	60.00	50.00	
†30	F	150.00	40.00		
*30	F	125.00	50.00	25.00	Aug., 1920
*30	F	125.00	30.00		
*30	F	135.00	40.00	10.00	July, 1921
†32	M	150.00		20.00	June, 1920
32	F	125.00	30.00	10.00	Feb., 1922
*33	F	150.00		25.00	Oct., 1921
33	F	150.00	40.00	25.00	June, 1920
33	F	125.00		25.00	June, 1920
34	F	150.00	100.00	25.00	1920
*34	F	130.00	40.00	30.00	
34	F	150.00			
35	F	150.00	30.00		
35	F	125.00		25.00	Jan., 1918
35	F	100.00	40.00	15.00	Oct., 1920
35	F	200.00	40.00	50.00	Jan., 1921
35	F	125.00	40.00	25.00	Jan., 1921
35	F	150.00	40.00		
35	F	125.00	40.00	10.00	July, 1921
35	F	185.00	40.00	25.00	1919
†35	F	125.00	40.00	25.00	April, 1920
†35	F	75.00	40.00		
35	F	100.00	25.00	20.00	Aug., 1919
35	F	150.00	25.00	30.00	July, 1921
*35	F	125.00	50.00	25.00	Oct., 1920
35	F	125.00	40.00	25.00	1918
35	F	100.00	28.00		
*35	M	125.00	40.00		
35	F	165.00	40.00	15.00	June, 1922
35	F	150.00	40.00	15.00	Mch., 1922
*35	F	165.00	50.00	16.00	Nov., 1921
35	F	175.00	75.00	37.50	Jan., 1921
35	F	125.00	40.00	12.50	Jan., 1922
35	F	125.00	65.00	25.00	Jan., 1920
35	F	150.00			
35	F	125.00	75.00	25.00	June, 1920
*35	F	125.00	40.00	25.00	May, 1921
35	F	100.00			
†35	F	150.00	65.00	15.00	July, 1921
36	F	125.00	41.66	25.00	Jan., 1920
*36	F	100.00	49.00		
36	F	175.00	75.00		
†37	F	150.00		25.00	Jan., 1921
38	F	125.00	20.00	15.00	1919
†39	F	150.00		25.00	Oct., 1921
40	F	100.00			
†40	F	175.00	30.00	25.00	1918
†40	M	125.00	40.00	25.00	Feb., 1921
40	F	140.00	40.00	15.00	1921
40	F	145.00	25.00		
*40	M	101.00	40.00		
40	F	200.00	60.00	50.00	Oct., 1921
*40	F	125.00	40.00		
40	F	125.00	40.00	25.00	1918
40	F	150.00	40.00	25.00	1919
*40	M	200.00	40.00	50.00	Jan., 1922
40	F	101.00	40.00	9.00	June, 1920
40	F	125.00	60.00		
40	F	175.00	40.00		
40	F	130.00	50.00	15.00	June, 1921
40	F	100.00	40.00	25.00	Jan., 1921
*40	M	150.00	40.00	25.00	May, 1922
†40	F	200.00			
40	F	125.00	50.00	25.00	Oct., 1918
40	F	175.00	40.00	16.66	Oct., 1920
40	M	180.00		20.00	Dec., 1921
40	F	110.00	40.00	15.00	June, 1920
†40	M	216.66	41.66	41.66	Oct., 1920
40	F	125.00			
40	F	130.00		5.00	Oct., 1921
40	F	150.00	50.00	25.00	Jan., 1920
40	F	125.00	75.00		
40	M	125.00			
40	F	175.00	50.00	50.00	July, 1920
40	F	150.00		42.00	Jan., 1920
†40	M	300.00			
41	F	150.00	60.00	25.00	Oct., 1921
42	F	150.00	37.50		
42	F	150.00	40.00	25.00	Jan., 1922
*44	M	150.00	50.00		
†45	F	150.00	40.00		
45	F	125.00	40.00	25.00	1921
†45	M	225.00	30.00	25.00	June, 1921
45	F	125.00		25.00	1920
45	F	125.00		25.00	1920
*45	F	150.00	60.00	25.00	May, 1921
46	F	125.00	30.00	25.00	July, 1920
46	F	125.00	75.00	10.00	Oct., 1921
48	M	291.66	41.75	25.00	Jan., 1921
48	F	150.00	25.00	25.00	Oct., 1920
		50 to 74 Bed Group			
†50	M	180.00		16.00	April, 1920
50	F	125.00		15.00	Jan., 1921
†50	M	500.00			
50	F	150.00	40.00	25.00	Mch., 1920
†50	F	100.00	32.00	20.00	June, 1921
50	F	200.00	65.00	33.00	1921
†50	F	150.00	25.00	25.00	Jan., 1920
50	M	100.00	40.00	5.00	April, 1922
†50	F	160.00	40.00	35.00	1921
50	F	150.00	40.00		
50	F	200.00	60.00	50.00	May, 1921
50	F	150.00	50.00	25.00	Oct., 1921
*50	F	90.00	50.00	10.00	1916
†50	F	175.00			
50	F	125.00	40.00		June, 1920
50	F	125.00			
50	F	150.00	35.00	25.00	1919
50	F	125.00		15.00	Jan., 1922
50	F	200.00		50.00	Nov., 1921
50	F	125.00		25.00	April, 1922
*50	F	208.33	75.00	41.66	Jan., 1920
50	F	125.00	50.00	25.00	Jan., 1921
50	F	150.00	36.00	25.00	April, 1922
50	F	125.00		25.00	Jan., 1921
50	F	100.00			
50	F	125.00	25.00		
50	F	125.00	50.00		
50	F	125.00		Bonus	
50	F	150.00		50.00	Jan., 1921
50	F	150.00	20.00	25.00	Jan., 1921
*50	F	200.00	49.00	100.00	Jan., 1919
50	F	150.00	40.00	13.00	1920
50	F	175.00	50.00	25.00	1921
50	F	200.00	80.00	50.00	Oct., 1921
50	F	150.00	50.00	25.00	Oct., 1921
50	F	100.00	50.00	25.00	Nov., 1919
50	F	150.00	41.66		
50	F	150.00	56.00		
50	F	125.00	40.00		
50	F	200.00	50.00	25.00	1920
50	F	150.00	25.00		
50	F	125.00	50.00		
*50	M	175.00	50.00	50.00	1918
50	F	200.00	60.00		
50	F	125.00	40.00		

No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase
*50	F	150.00	35.00	25.00	April, 1921
50	F	150.00	30.00	25.00	June, 1920
*50	F	100.00	40.00	15.00	Jan., 1920
*50	F	250.00	40.00		
50	F	160.00	40.00	20.00	June, 1922
50	F	125.00	40.00	25.00	May, 1921
50	F	125.00	40.00		
50	F	125.00	75.00		
*50	F	125.00	15.50	15.00	June, 1920
50	F	100.00	40.00		
†50	F	175.00	50.00	50.00	Jan., 1922
50	F	166.00	41.00	25.00	May, 1922
50	F	150.00	40.00	50.00	1920
†50	F	100.00	25.00	25.00	June, 1919
†50	M	150.00	44.00		
50	M	150.00	55.00		
50	F	130.00	40.00	30.00	Jan., 1922
50	F	150.00	50.00	50.00	Jan., 1921
50	F	125.00	40.00		
†50	F	100.00	40.00		
50	F	130.00	40.00	10.00	1921
50	F	150.00	40.00	15.00	1921
50	F	125.00	40.00	25.00	May, 1922
50	F	160.00	40.00	25.00	June, 1921
50	F	100.00	130.00	25.00	Oct., 1921
†50	M	125.00		25.00	1915
50	F	125.00	38.00	25.00	1918
50	F	110.00	50.00		
50	F	166.00	40.00	15.00	Sept., 1921
†50	F	200.00	Board	25.00	Jan., 1920
†50	F	125.00	75.00	25.00	1919
50	F	125.00	40.00		
*50	M	200.00	43.00		
50	M	125.00	25.00	16.00	Jan., 1921
50	F	115.00			
50	F	150.00	40.00		
50	F	125.00	22.00		
50	F	125.00	30.00		
50	F	125.00	50.00		
50	F	166.00	40.00	25.00	Sept., 1921
51	F	125.00	50.00		
†52	F	200.00	30.00	25.00	Jan., 1922
†52	F	120.00	40.00	20.00	1919
52	F	166.66	40.00		
52	F	165.00	50.00	15.00	Oct., 1921
52	F	150.00	40.00		
†52	F	250.00			
52	F	125.00	40.00	15.00	Oct., 1920
52	F	125.00	35.00	25.00	Feb., 1921
52	F	150.00	40.00		
†54	M	200.00			
54	F	133.00	40.00	16.00	1919
54	F	150.00			
54	F	175.00	43.33	25.00	Dec., 1921
55	F	150.00	40.00	25.00	1921
55	F	150.00	40.00	25.00	Sept., 1921
55	F	166.00	40.00	41.00	Feb., 1922
55	F	250.00	83.33	50.00	Mch., 1922
55	F	125.00			
†56	F	150.00	30.00	41.00	Jan., 1921
56	F	140.00	50.00	10.00	1921
56	F	150.00	45.00	25.00	April, 1921
57	M	275.00	50.00	25.00	Jan., 1922
†60	M	300.00	25.00	50.00	Jan., 1922
60	F	100.00	40.00	10.00	1920
60	F	125.00		25.00	Jan., 1928
60	F	150.00	50.00	25.00	June, 1921
60	F	166.66		16.66	Dec., 1921
†60	M	150.00	40.00	25.00	July, 1921
60	F	141.66	33.33	25.00	Jan., 1922
60	F	125.00	41.66	25.00	Jan., 1921
60	F	166.66	40.00	41.66	1918
*60	F	200.00	83.33		
*60	F	150.00			
60	F	150.00	58.33		
60	M	283.33	160.00	58.33	Mch., 1922
†60	M	283.33		41.66	1917
†60	M	300.00			
60	F	110.00	25.00		
†60	F	135.00	40.00	10.00	Nov., 1921
60	F	175.00	40.00	25.00	Jan., 1922
60	F	150.00	40.00	25.00	Jan., 1922
†60	M	166.00	50.00	33.00	1919
60	F	150.00	50.00	12.50	Nov., 1920
60	F	150.00			
60	F	125.00	30.00	25.00	Mch., 1922
60	F	165.00	40.00	16.00	June, 1920
60	F	175.00	40.00	25.00	Jan., 1921
*60	F	125.00	40.00		
60	F	150.00	40.00		
60	F	150.00	8.50		
60	F	160.00	50.00	10.00	Jan., 1922
†60	F	250.00	40.00	75.00	July, 1920
60	F	110.00	40.00	10.00	Jan., 1922
60	F	150.00		25.00	1921
60	F	125.00	30.00		
†60	F	125.00	75.00	50.00	June, 1917
60	F	200.00	40.00	50.00	April, 1922
60	F	150.00	83.00	25.00	Jan., 1919
†60	M	208.00		68.00	1920
60	F	110.00	50.00	10.00	Aug., 1920
†60	F	175.00	40.00	25.00	June, 1921
62	F	292.50	25.00	141.66	Mch., 1922
†62	F	135.00	40.00		
64	F	200.00	10.00	50.00	July, 1922
64	F	150.00	75.00	20.00	Jan., 1922
65	F	225.00	60.00	25.00	April, 1922
†65	F	150.00	50.00		
65	F	150.00	34.00	25.00	May, 1920
65	F	175.00	75.00	25.00	June, 1921
65	F	125.00	50.00	25.00	Feb., 1922
65	F	150.00	42.00	25.00	Oct., 1920
†65	F	150.00	30.00	25.00	July, 1919
65	F	150.00	40.00	25.00	Aug., 1920
65	F	175.00	25.00	25.00	Nov., 1921
65	F	100.00			
65	F	175.00	42.00	50.00	Aug., 1919
†65	M	210.00		20.00	Jan., 1921
*65	F	200.00	65.00		
†65	M	250.00		25.00	Jan., 1922
65	F	150.00	40.00	25.00	Nov., 1920
65	M	300.00	40.00	50.00	1919
65	F	150.00	50.00	15.00	Jan., 1922
†65	F	225.00		60.00	Jan., 1922
65	F	150.00	75.00	25.00	July, 1921
*65	F	165.00	70.00	25.00	Aug., 1920
†66	F	83.00	12.00	16.60	Dec., 1920
†67	F	125.00	40.00	25.00	June, 1921
67	F	150.00	20.00		
†68	M	166.00			
68	F	150.00	44.00	2.00	Mch., 1921
68	F	150.00	90.00	25.00	Nov., 1921
68	F	175.00	75.00	25.00	May, 1920
70	F	200.00	40.00		
70	F	100.00	40.00	20.00	Sept., 1919
†70	M	300.00		50.00	May, 1921
70	F	150.00	50.00		
†70	M	100.00			Jan., 1920
†70	F	100.00	50.00	25.00	Aug., 1920
70	F	175.00	40.00	25.00	Nov., 1920
70	F	150.00			
†70	F	175.00	60.00	150.00	1919
†70	M	150.00			
*70	F	125.00	180.00	40.00	Oct., 1920
†70	M	200.00	60.00		
70	F	140.00		15.00	Jan., 1921
†70	M	250.00	25.00		
*70	F	165.00	50.00	15.00	Oct., 1919
70	F	150.00	40.00	16.00	May, 1922
70	F	150.00	40.00	16.67	April, 1920
70	F	100.00	40.00	25.00	1921
†70	F	120.00	40.00		
70	F	100.00		80.00	
70	F	125.00	40.00		
72	F	150.00	58.00	25.00	Jan., 1921
72	F	75.00	40.00	25.00	Jan., 1918
		75 to 99 Bed Group			
75	F	150.00	30.00		
75	F	200.00	78.00	50.00	June, 1921
75	F	125.00	25.00		
†75	F	150.00	27.00	22.00	1920
75	F	150.00	60.00		
†75	F	140.00	40.00	15.00	Jan., 1922

No. of Beds	Sex of Supt.	Monetary Salary	Monetary Equivalent of Maintenance	Amount of Last Increase	Date of Last Increase
75	F	125.00	35.00	25.00	July, 1921
75	F	200.00	35.00	25.00	May, 1922
75	M	165.00		20.00	May, 1920
75	F	167.00		42.00	Jan., 1921
75	M	270.00		Reduced $27	Feb., 1922
†75	F	200.00	40.00	25.00	1920
75	F	150.00	40.00	25.00	1921
75	F	190.00	50.00	10.00	July, 1921
†75	F	125.00	30.00		
†75	M	250.00		75.00	Jan., 1922
75	F	100.00			
75	F	150.00	25.00	25.00	1919
75	F	125.00	40.00		
75	F	150.00	40.00		
75	M	150.00	50.00	50.00	1921
75	F	150.00	40.00	25.00	1918
75	F	150.00	30.00	25.00	May, 1922
75	F	75.00		15.00	Aug., 1921
†75	M	200.00		30.00	Jan., 1922
†75	F	125.00	40.00	25.00	Aug., 1920
75	F	200.00		25.00	Dec., 1920
†75	F	100.00	75.00	25.00	1918
†75	F	150.00	30.00	25.00	Nov., 1919
75	F	166.00		42.00	Oct., 1920
75	F	175.00	50.00	25.00	June, 1921
75	M	125.00		25.00	Feb., 1921
†75	F	400.00	100.00	100.00	Jan., 1921
75	F	150.00		25.00	1920
75	F	150.00	30.00	25.00	Aug., 1920
75	F	200.00	70.00	50.00	June, 1920
75	F	200.00	40.00	25.00	June, 1920
75	F	190.00	55.00	25.00	Jan., 1922
†75	F	125.00	25.00	25.00	June, 1922
76	F	125.00	40.00	25.00	1920
76	F	200.00		50.00	1919
†79	F	125.00	41.00	41.00	
†80	M	200.00	66.00	25.00	May, 1922
80	F	150.00	50.00	25.00	Oct., 1920
†80	M	416.00	12.00		
†80	F	200.00	125.00		
80	F	116.00	48.72		
†80	F	125.00	35.00	25.00	1921
80	F	166.00	40.00	16.00	Jan., 1921
80	M	458.00	40.00		
†80	F	166.00		66.00	Mch., 1919
†80	F	150.00	40.00	10.00	July, 1920
†80	F	250.00	40.00	100.00	May, 1920
†80	M	225.00			
80	F	175.00	42.00	25.00	Jan., 1922
80	F	150.00	30.00	25.00	Aug., 1920
*81	M	200.00	90.00	25.00	Jan., 1922
82	F	150.00	40.00		
*85	F	185.00		35.00	Mch., 1921
†85	F	150.00	40.00		
†85	M	300.00			
85	F	175.00	35.00	25.00	Jan., 1922
†85	M	250.00	60.00	50.00	1920
85	F	125.00	40.00	25.00	Sept., 1920
85	F	175.00	25.00	25.00	May, 1919
*86	M	200.00	90.00	25.00	Jan., 1922
†86	M	300.00			
86	F	125.00	40.00	25.00	1920
†86	F	250.00		50.00	Jan., 1920
†86	M	375.00		50.00	Jan., 1922
†86	F	150.00			
†87	F	250.00	40.00	50.00	1918
†88	M	250.00		42.00	Oct., 1921
90	F	125.00	42.00		
90	F	150.00	33.00	25.00	May, 1921
90	F	175.00	25.00	25.00	Sept., 1921
†90	F	175.00	40.00	25.00	Mch., 1922
90	F	124.00			
†90	F	200.00		50.00	Aug., 1921
90	F	100.00	40.00	25.00	1919
90	F	175.00	40.00		
90	F	150.00	40.00		
90	F	150.00	40.00		
90	F	150.00	50.00		
90	F	150.00	41.66	16.66	April, 1921
*90	M	125.00	40.00		
†90	M	225.00		50.00	Jan., 1920
90	M	416.66	60.00		
†90	M	200.00	30.00		
90	F	200.00	40.00	25.00	Mch., 1921
90	F	125.00			
92	F	175.00	60.00		
93	M	250.00	42.00		
*93	F	100.00	32.00	16.66	1920
95	F	100.00		80.00	April, 1921
95	F	200.00	50.00	25.00	Mch., 1921
96	F	110.00	40.00	20.00	May, 1920
97	F	130.00	40.00	15.00	June, 1921

ADEQUATE SYSTEM OF GARBAGE DISPOSAL

Food waste in the hospital will continue until an adequate system of garbage disposal is instituted, writes C. J. Decker, superintendent of the Toronto General Hospital. The installation of such a system is not difficult nor does it require expensive equipment. Each unit must, however, be provided with a standard garbage can of adequate size. These cans must be collected daily or oftener if necessary and their contents weighed and recorded. This work should be handled by a man who is chosen not simply because he will engage in that type of work, but rather because he feels the importance of the work he is doing and will take an interest in it and render accurate reports. These reports should reach the superintendent daily and they should get the attention due them.

In smaller hospitals the head nurse of each unit should be told of the result of weighing the waste coming from that unit daily and any fluctuation should be discussed. In large institutions charts should be provided showing the per capita waste for each unit; these should be distributed at least once a month and the superintendent should comment in writing on the results in each case. I am satisfied that this system will reduce food waste in your hospital. Any sudden rise in the edible waste will usually indicate a defect in the quality of the food bought or fault in preparation. Heavy garbage usually means one of two things, either that the patient is being served too much food or food for which he has no desire. This will be determined through the procedure I have just outlined; if it is found true, then a system should be inaugurated that will prevent the serving of food not desired by patients.

SEEK NEW SANATORIUM SITE

Convinced by city engineers and officials that the construction of a tuberculosis sanatorium near White Pond, N. Y., would contaminate the water supply of the city of New York, the Constructive Jewish Aid Society has given up its proposed sanatorium site and is seeking another location. Sites under consideration are at Tupper Lake, another near Saranac and a third on Long Island. At a hearing before officials of the state department of health, it was brought out that White Pond is a part of the Croton watershed and that the erection of a sanatorium there would jeopardize the city water.

Many lives and much property are lost every year because of accidents due to venereal diseases, says the U. S. Public Health Service. So great in fact are these losses that the National Safety Council has issued a bulletin on them. For instance, four serious recent railway wrecks were traced to employes who failed because they were suffering from paresis, which is a form of syphilis.

THE WORK OF THE SOCIAL SERVICE DEPARTMENT OF A STATE HOSPITAL

By AARON J. ROSANOFF, M.D., Los Angeles, Cal., Formerly Clinical Director, Kings Park State Hospital, Kings Park, Long Island

THE Kings Park State Hospital has over 5,300 patients, nearly 800 employes and twenty-two resident medical officers. It is located at a distance of forty-five miles from Brooklyn, whence it receives the great majority of its 1,000 to 1,200 annual admissions. One of the senior assistant physicians has been detailed on whole time to have charge of the social service department, which consists of six women social workers, one male attendant detailed as a social worker, two stenographers and a transportation agent.

The greater part of the work of the social service department is in connection with the hospital's parole system, which has been greatly extended during the past three years, as the following figures show.

On January 1, 1919, there were 288 patients on parole. On December 11, 1921, this number had risen to 889, the highest point in the rather long history of the hospital.

Further extension of the parole system of this hospital can undoubtedly be brought about, but for the time being its development is being delayed by the prevailing hard times and unemployment, which affect not only the patients but also their relatives and friends who, in better times, might be able to cooperate with the hospital by assisting the patients.

The social workers attend all staff meetings at which cases are presented for parole. In some cases, prior to granting parole, they visit the patients' homes or prospective places of employment and secure information which helps to decide whether parole be granted and, if so, to whose custody and under what conditions.

The usual parole period is one year, during which time the patient reports once a month at one of the out-patient clinics conducted at the Eastern District Hospital, Brooklyn, N. Y., every Thursday morning and evening, and at the Nassau Hospital, Mineola, L. I., every Monday afternoon. Two physicians and two social workers are in attendance at the clinic.

In case of a patient failing to report at the clinic personally, by letter or by telephone, he is visited by a social worker either at his home or at his place of employment. For convenience in such visiting the Borough of Brooklyn has been divided into districts, these being assigned to the different social workers.

A continual record is kept of each patient on parole, in which are included reports of his condition, work, etc., as observed from time to time, usually once a month, at the clinic or on occasions of the social worker's visits, or as they are made known to the hospital by letter or by telephone. Sometimes the custodian of the patient or a relative reports for him at the clinic or by letter. These reports constitute the basis of any after-care measures that may be undertaken: change of custodian, securing new employment, providing medical treatment at out-patient clinic, returning from parole, re-paroling for another year, etc.

In assisting patients to attain a social adjustment extra-murally the social service department often has the cooperation not only of relatives or prospective employers, but also of such organizations as the Board of Child Welfare, the Red Cross, the Department of Public Welfare, the City Employment Bureau, and private charities.

Although a large proportion of the patients released on parole since the inauguration of the extended system in this hospital have chronic psychoses of many years' standing and recovery in a medical sense is quite out of the question in their cases, yet, with the aid of our social service department, they have been helped to a social adjustment such as has made them not only self supporting but also, in some instances, successful to the extent of producing a surplus to put away in the bank or to help their families.

As an important by-product of the activities of the social service department may be mentioned an educational influence among relatives, friends, and employers of patients, charitable organizations, and others, leading to a more rational and more helpful attitude toward the so-called insane and a correction of traditional misapprehensions, prejudices and fears.

Among other activities of the social service department are to be mentioned the following:

(1) Field work on families of patients with general paralysis or other syphilitic conditions. Relatives of such patients are brought to the out-patient clinic for medical examination, including the Wassermann reaction, and, if found to be syphilitic, which happens in 15 to 20 per cent of the cases, are advised to put themselves under treatment, such treatment being offered them gratis if they cannot arrange for it otherwise.

(2) Obtaining case histories from patients' relatives or friends who come to the hospital and, where necessary, verifying and supplementing such histories by field investigation.

(3) Making all required psychometric tests both in cases admitted to the hospital and in those treated in the out-patient clinics.

(4) Assisting in research work carried on in the hospital.

From a financial standpoint it can readily be shown that a state hospital can no longer afford to conduct its operations without the aid of a social service department. The saving in the maintenance of chronic patients amounts to many times the cost of maintaining such a department.

But the matter should be regarded not only from that standpoint, but also, and mainly, from the standpoint of the general gratification and benefit accruing to the patients, their relatives, friends, employers and all others concerned. This manifests itself in an unmistakable improvement in morale both in the hospital and within the entire sphere of its influence.

The discussion of pros and cons of a special social department and an extended parole system in a state hospital cannot be entered upon here. The reader is referred, instead, to previously published contributions on this subject.*

*Mary C. Jarrett: Applications of Sociology in Psychiatry. Manual of Psychiatry, edited by A. J. Rosanoff, fifth edition, 1920.—A. J. Rosanoff and T. S. Cusack: Parole System and Its Relation to Occupational Therapy. Amer. Journ. of Insanity, Oct., 1920.—W. C. Garvin: How the Number of Parole Patients Was Increased at the Kings Park State Hospital. N. Y. State Hospital Quarterly, Nov., 1920.—G. W. Mills: The Activities and Uses of a Parole Clinic, N. Y. State Hospital Quarterly, May, 1921.

NURSING AND THE HOSPITAL

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MENTAL HYGIENE IN ITS RELATION TO PRESENT-DAY NURSING*

By L. VERNON BRIGGS, M.D., Director, Massachusetts Society of Mental Hygiene, Boston.

WHAT confronts the sufferer from mental disease today is, first, the difficulty of finding a physician who is educated in the care and treatment of mental sickness, and, second, the difficulty of securing the services of a nurse who has had experience along these lines. Generally these difficulties are so great and the patient's needs are so urgent that the only avenue of escape is for the family to send him to a private sanitarium for mental diseases or to a state hospital. And even in these special hospitals, in many of which we have skilled medical attendance, it is at present often impossible to provide adequate nursing.

It is not possible to separate mental hygiene from hygiene in general. Our mental and physical functions are so closely interwoven and so mutually interdependent that they cannot be regarded separately. The problem of nursing the mentally sick is not that of caring for the frankly insane (as they are still erroneously called)—nor for the feeble-minded—nor the nursing of raving maniacs or imbeciles—but of the care of large groups of individuals whose physical symptoms find their origin in poor mental adaptation, in personality defects, in factors in the environment, or in mental peculiarities due to subtle toxic conditions which can only be determined by the psychiatrist through the constant observation of highly trained and intelligent nurses. Where is there a nurse who would refuse to take a case of typhoid fever or of puerperal conditions of chronic interstitial nephritis with mental disturbance, and yet these disturbances do not differ materially from those of the so-called insane, whom the same nurse would probably decline as patients. This attitude is not to be wondered at, for as Thom very aptly reminds us it is only a few years—perhaps ten—that psychiatry has been associated with general medicine. But now we meet with conditions requiring mental nursing not only in the special hospitals for mental diseases and in the community, but in its general hospitals, in the industrial field and in the schools, where nurses skilled in mental hygiene are to take their place in the field of preventive medicine.

There are two things I want to impress upon you, first, I want to disassociate the idea of training in mental nursing from that of the care of the so-called insane or "crazy" people; that is an infinitesimal part of your work as a nurse. It has been said that the brain is like a good piano badly played upon. Mental disturbance requiring the most skilled nursing may often be the result, not of a defective or diseased brain, but of disease of some particular organ of the body, forming toxins which in the circulation play upon the brain and produce mental symptoms. Secondly, to have mental nursing one of the required subjects in your training would not mean that you were to be relegated to state hospitals. It would only mean that you were to get there a part of your training which will enable you to better take care of mental disturbance no matter in what form it may appear.

Few people, even among the medical profession, have any idea of the prevalence of mental and nervous diseases. Do you realize that in Massachusetts in the year 1920 one out of every 20 adults who died in the entire state died in a state hospital for mental disease and twice as many enter and leave the hospital as remain to die there? This means that one out of every ten of our adult population is at some time during his life a patient in a hospital for mental and nervous diseases. And this is not taking into account the unrecognized cases, the neglected cases and the cases receiving treatment in their own homes! How many of these deaths from mental disease might have been prevented by early recognition and intelligent nursing! Certainly training in mental nursing is proportionately more important than training in obstetrical or surgical nursing. And yet not one general hospital training school in the state requires any training in the care of mental cases.

Mental Nursing Not in Curricula

The situation in the state at the present time in this branch of work is deplorable. It is with great difficulty that a physician can obtain the services of a nurse trained in the care of the mentally sick. The difficulty is so serious that many patients are sent to state hospitals who might be nursed in their own homes away from surroundings suggesting mental illness. Why is this so? The usual answer made by the nurse is: "They are difficult cases. We should we take them when we already have more than we can do with the medical and surgical cases?" That is not really the reason. I do not believe that nurses train for their profession to the end that they may pick and

*Read before the League of Nursing Education of the Massachusetts State Nursing Association, February 18, 1922.

choose the easy or agreeable cases. To be sure, nurses now specialize in surgical work, in obstetrical work, or typhoid or tuberculosis cases, but that is after they have received their general training and have registered. The undergraduate does not prepare specially for any one branch of nursing any more than the undergraduate physician devotes himself to a single specialty. It is not possible for either of them to know whether they are going to be more efficient in one branch of the service than in another until they have had the general training upon which all the rest is based. All specialties are interdependent.

Now what is most regrettable is the fact that most training schools for nurses do not require the study of the care of mental and nervous diseases, but leave these subjects entirely out of their curricula. The nurses, therefore, not only lose the opportunity to find out whether they are specially adapted to this important and profitable branch of the service and would like to choose it for a life work, but they are deprived of what should be an important part of their training for general nursing, and a large class of patients are left without the service which all nurses should be able to give. For one of the strongest reasons for including mental hygiene in the education of nurses is that it would be of value to every nurse to be able to apply the principles of the care of mental and nervous cases to her every-day patients. There is scarcely a patient to whom a nurse is called today who has not an element of mental or nervous instability, especially when mind and body are weakened. A lack of education along these lines makes the case much more difficult for the average nurse. Society is like a complicated machine made up of millions of parts, and the members of society with mental troubles are defective parts of that machine which prevent its working smoothly. But they cannot be scrapped like the defective parts of a machine merely because they clog the social machinery, for they are human beings. They generally feel themselves to be out of adjustment and suffer accordingly, for by the law of our nature we can only be happy when we are filling our normal place in the scheme of things. The intelligent nurse helps to repair these defective units that they may be replaced in that part of the social machine where they are best able to function.

It is a great satisfaction to help bring the unsettled mind back to normal and it requires a much higher training than to assist in the cure of physical ills. The mind is more interesting than the body to study, to treat and to nurse.

Opportunities in Mental Nursing

A nurse thoroughly trained in mental health work in all its branches has one of the greatest opportunities for service that can be given to anyone, opportunities which may be extended into the families and homes of her patients and into the community at large. The day is not far distant when she will become a teacher of mental health in the family and in the community. It is the nurse who, in a great measure, will be responsible for starting the child on the road to mental stability, and the training which a nurse can give to a child from birth, and especially during its school life may make success or failure when that child enters society and has to face the obstacles and competition of adult life.

Education in mental health, in addition to enabling the nurse to understand and handle her patients much better than she would otherwise be able to do, would also enable her better to handle herself in the presence of nervous and apparently unreasonable patients. Few nurses today know enough of mental hygiene to conserve their own nervous energies by taking proper care of themselves so that they are not unnecessarily irritated and fatigued by these trying cases whose behavior in illness varies from the normal standard. These conditions a nurse with suitable training in mental hygiene should meet successfully and cheerfully. Those who have had this training have a storehouse of reserve force which they may call upon under the most trying circumstances. The lack of mental training is a real neglect in the nurse's education and shows a want of appreciation of the needs of the patient and of the nurse herself, as well as of the trend of the ideals for which she is working.

The nursing in our mental hospitals today is gradually improving, but it is still far from satisfactory. Recently, in addressing a committee, I made a statement that we should have a higher grade of nurses in our state hospitals for the mentally ill; that, as a whole they were not up to the standard of general nurses, though I stated that among them there were many who were well-trained and efficient and whose services were invaluable. No words can express the appreciation and gratitude of the patients and of their families and friends for what some of these devoted women are doing. It is to be hoped that the time is not far distant when their associates will be given equal training and that the highly specialized and often most interesting work in our mental hospitals will be done by nurses, trained or in training, who are equally faithful and intelligent. But I added in my statement to the committee that we have many so-called nurses and attendants in mental hospitals who are ignorant, lazy, and stupid, a floating population of low-grade individuals, who know little and care less about the scientific nursing and humane care of these mentally ill people. This remark of mine was somewhat misquoted in the newspapers, and I was criticized by one of the leading members of your profession for having attempted to overthrow the morale of the nursing schools in the state hospitals, which are struggling against long odds to establish high ideals without much support or encouragement from the nursing profession in general. This critic has not appreciated the fact that I was attempting to enlist the support of this committee for constructive measures to raise the standard of nursing and to educate better the student who has chosen to devote her life to the amelioration of suffering.

There was no higher call during the war—there is no higher call today in time of peace—than that of the nursing profession. But this is a call to help all who are ill and suffering. There is no class of patients who can be benefited more by tactful and intelligent nursing than the mentally ill, for a large portion of mentally nervous disorders are curable and all can be benefited by proper care and treatment. There is no class of patients for whom the physician alone can do so little and the nurse so much; in many instances the doctor is helpless without the nurse. No two cases are alike, few can be early classified, and the call for quick decision, tact and initiative on the part of the nurse is much greater than for any other type of disease.

There is no class of patients so large today as that of the mentally ill; mental diseases call for more nurses than all other diseases put together, for there are more beds for mental patients in the hospitals of the United States today than there are in all our general medical and surgical hospitals added together. So have not we, who are working in the cause of the mentally ill, a right to ask that nurses be educated in the care and treatment of nervous and mental patients as well as of other patients,

and has not the *nurse*, who gives several years to her professional training a right to demand that her education be rounded out and completed, that she may take her place with these patients as well as with those suffering from other ills?

The demand for nurses with psychiatric training is more than doubling each year. If nurses are not given this training how are we to supply the demands of the industrial plants, the hospitals, the courts, the charitable organizations, the schools and the community? Every public school requires a nurse with psychiatric training, and the demand is always likely to be greater than the supply. Indeed so great is the necessity for a better understanding of mental problems in the schools that it is safe to say that we must go farther and not only demand that school nurses have psychiatric training, but we shall very soon also require that our teachers shall have some knowledge of psychiatry and mental health and include these subjects as a part of the curriculum of every normal school and college. The number of students who break down under the present courses of study is alarming. It is well for the nurse to understand one or two of the causes which play an important part in the breaking down of our present-day society. I will mention two that have been pointed out by two great men.

Two Causes of Mental Disorders

First, the great Italian, Bianchi, emphasizes among other things the stabilizing effect of work on the mind and deplores the prevailing conception that the fewer hours we have to work, the better off we are. He says, "This is the view which politicians and labor leaders—to promote their own selfish interests—are impressing on the public. The result is that the shortening of the hours of labor, instead of giving leisure for home duties and family life, is deteriorating character and mental health, as the free hours are devoted to loafing. "Work," he says, "the great stabilizer of the nervous system, is abhorred and shirked more and more—a sad perversion of the ideal aimed at in the early agitation for the eight-hour day."

The great French authority, Pierre Janet, declares that the present day society has another factor to contend with, which results in the breaking down of many minds and the resort to alcohol, drugs, etc. He says:

"I have already had occasion to point out in this connection a type of mental overwork that is typical of the age in which we live. The philosophic ideas in regard to the equality of man have brought to a common level the ambitions of all classes. They have subjected all minds, no matter what the caliber, to efforts that our fathers never thought of making in the same manner. A dramatic author once said: Several generations are required to make a minister out of a janitor's son.

"If we could make the social struggle less severe; if we could check the desire to attain social position too rapidly, and if we could discourage dangerous ambitions, could we not unite what now seems irreconcilable: freedom of thought and tranquility of beliefs? These are great questions and more closely linked to the problem of alcoholism, and also that of race suicide, than is commonly supposed."

The dictum that "All men are equal," a mistranslation of the "right of all men to an equal opportunity," on which our democracy is based leads many to strive to compete much beyond their mental and physical strength. The result of instilling this idea that all are equal to shouldering responsibility or reaching equal heights into the minds of those who are not stable, who are not gifted with the power to compete with their fellows, is that they are forced to the front and encouraged to take positions and responsibility they never should take. They fall by the wayside one after the other, some sooner some later, and many of the patients today in the hospitals are the victims of this application of the democratic idea. They have believed that all men are equal mentally and physically, only to find too late that they have limitations which should have been recognized early in their lives. And here is another field for the properly educated nurse who has daily contact with the unstable child or adult; she should be able intelligently to size up their limitations, and at least in the case of the child, help him to avoid the fatal result of too great ambition, and later the assumption of too great responsibilities.

Prejudice Is Based on Superstition

The difficulty in interesting nurses to take training in mental health is due in the first place to prejudice—to the prejudice of the nurses themselves and the community at large—against these unfortunates. This prejudice dates back to the dark ages when the mentally afflicted were supposed to be possessed by evil spirits and were tied to the pillars of the churches and whipped by the priests, whipped to drive the devils out of them. It was this tradition which later led to the abuse of the mentally ill in their homes and in institutions, for whipping had been allowed by the churches and towns were permitted to chain these poor unfortunates in the almshouses and prisons, so why should not ignorant attendants punish and maltreat them? Even in comparatively recent times, these people have been treated not as patients but as dangerous malefactors, relegated to almshouses and prisons where they could do no harm with no thought of the harm that was being done them. That prejudice, itself based on superstition, prevailed all over the world, and its influence is still felt by the nurses of today. And why not? Has stress been laid during the training of these nurses upon the fact that the brain is only one of the many organs of the body, which can become diseased the same as the liver or lungs or kidneys? Have they been told that diseases of the brain are the same in medical importance and no more hopeless of cure under proper medical and nursing care than diseases of any of the other organs of the body?

The brain is the most highly developed organ of the body and its diseases call for the most scientific nursing. The study of the care of mental illness requires a higher intelligence and education than of tuberculosis of the lungs or disease of the kidneys, etc. because we have in the brain not only a possible physical condition in a very complex organ, but a psychic condition. Those who treat these cases most understanding not only the organic brain but its functions, its variations from normal and its susceptibility to environment. A large portion of cases of so-called brain disease show no sign of disease at autopsy. It is in this large group of cases that the study of the individual and his environment rather than of the brain must be made and the treatment and care directed accordingly.

Psychiatry is such a deeply interesting study that once a physician really enters the realm of mental medicine he rarely leaves it for any other branch. In fact I know of no man who has ever left the practice of psychiatry for any other specialty after having gone into it deeply enough to understand what it means. I believe it would be the same with the nurse, and that if nurses should voluntarily make the study of mental nursing a part of their curriculum, or if it should come to be a required subject, many would be found who would choose it for

their life work because the field is so tremendous and so interesting and they can accomplish so much good.

There is one important point which must not be forgotten in speaking of the desirability of education of nurses in mental health work, and that is the benefit to the thousands of patients in our state hospitals—state hospitals for mental diseases today, but state hospitals for mental health tomorrow. These hospitals are greatly in need of nurses with skill and scientific training, and their training schools will undoubtedly develop to meet the demand which is bound to come for training affiliates from the general hospital training schools as well as the demand for post-graduate courses for registered nurses.

The whole number of nurses and attendants employed in the ward service of our state hospitals wholly in the department of mental diseases for the year ending Nov. 30, 1921, was 1,464.76, and increase of 211.67 over the previous year. There were seventy-two graduates only in this group. There were 3.61 rotations in this group compared with 4.18 rotations the previous year, and the average length of the interval between rotations was 3.35 months, as compared with 2.90 months the previous year.

Affiliations With General Hospitals

The affiliations in our state hospitals are as follows:

Institution	Nurses graduated in 1921	Affiliations
Worcester Hospital...	13	Boston City Hospital.
Taunton Hospital....	13	12 months' service at Boston City Hospital.
Northampton Hospital	5	12 months' course at State Infirmary, embracing surgery, diseases of children, obstetrics and gynecology.
Danvers Hospital.....	6	Bellevue and Allied Hospitals.
Westborough Hospital	4	Massachusetts Homeopathic Hospital, 1 year's instruction in surgical, gynecological, obstetric and pediatric nursing.
Boston Hospital.....	17	Boston City Hospital, 12 months' training in contagious diseases, obstetrics, operating room technique, general medical and surgical.
Psychopathic Hospital	0	No training school.
Grafton Hospital.....	9	Boston City Hospital.
Medfield Hospital.....	4	(Female) Bellevue and Allied Hospitals.
Gardner Colony	0	.....
Monson Hospital	1	Bellevue and Allied Hospitals.
Foxboro Hospital	0	No training school.
Mass. School for Feeble-minded	0	No training school.
Wrentham School	0	No training school.
Bridgewater Hospital.	0	No training school.
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While the foregoing table represents the affiliations, one must not be led to believe that the affiliation is mutual. For not one of these general hospitals sent to the state hospitals, to which they are affiliated, any pupils.

A second reason why we find it difficult to get good nurses for mental cases is that the education of the physicians themselves has been neglected. It is only within the last year that psychiatry has been made a required subject in Massachusetts medical colleges, and a law has been passed making it obligatory (beginning in 1923), for all physicians to pass an examination in psychiatry before they can register to practice in the state. It is no wonder that physicians have done so little in mental medicine when they have not been trained to recognize mental diseases, and they have naturally not expected their nurses to understand mental nursing. Now that psychiatry is an important part of the physicians' training, the younger men, at any rate, will be demanding nurses competent to look after their patients. It is part of the program for preventive medicine.

Psychiatry in State Examinations

Another important part of the program to meet present-day medical needs is that, as physicians are obliged to pass an examination in psychiatry, so nurses must qualify in psychiatric nursing before they can register to practice in the state. This training would give the nurse a better chance to deal successfully with her cases, mental and physical. It would make her one of the "sentinels of mental health," as Donald Laird puts it, and help to afford an opportunity for psychiatrists, who now concentrate their efforts upon institutional cases, to turn their attention to the community and become real hygienists.

The physicians, newly awakened to the importance of mental disease, and especially the young general practitioner who has himself been trained in psychiatry, will demand that his nurse shall at least know how to observe and report early mental symptoms and care for incipient cases of mental disease, often preventing their further development. *This* is a very important branch of mental hygiene, and no one has a larger part to play in it than the well-trained general nurse, if she has the vision to rise to the occasion and be prepared to meet the call which is already becoming more and more urgent. The future development of mental hygiene, not only in private practice but in public health work, in the school, in industrial medicine and in the community, is assured. Is the nursing profession ready to rise to this demand, or will it be necessary to create a new profession to meet it? If the leaders among our nurses demand both undergraduate training in psychiatric nursing for all general nurses and postgraduate training for teachers and specialists, there is little doubt that the hospitals will meet them half way and furnish it.

I believe that an exchange affiliation of the general hospitals with the state hospitals would be of great mutual benefit, furnishing in both general and mental hospitals more intelligent nursing care. In the state hospitals it would be the greatest encouragement to the faithful and efficient nurses now on duty. Our fourteen state hospitals graduated in the year 1920 only seventy-two pupils out of an average daily ward service of about 1,465.75 including nurses and attendants. These state hospitals have some affiliations with general hospitals, but the general hospitals send no pupils in exchange for those who go to them for training in obstetrics, etc. It is a crime and a blot on our civilization that patients in mental hospitals have not long ago been placed on the same basis of medical care and nursing as patients in our general hospitals. When the history of the state hospitals is finally written, an intelligent community will wonder how the present staffs of medical men and nurses have accomplished so much in the care and treatment of the patients, handicapped as they have been. They certainly should be awarded distinguished service medals for having held the fort for so many years before the arrival of reinforcements.

I have permission from the Rockefeller Foundation to tell you that in a report on "The Education of Nurses in this Country" which they are soon to publish, they recommend that all nurses shall have a course in mental hygiene, including at least three months in hospitals for mental diseases allied to general hospitals, before they

receive their diplomas. This is a great step, and unless I am mistaken, no recommendation made by the Rockefeller Foundation along the lines of medical work or improvement has failed to be favorably acted upon.

Summary

1. Psychiatry is no longer confined to asylums, prisons, almshouses. It is now one of the foremost problems of social and preventive medicine and is playing its part in educational, industrial, judicial and military organization.

2. Mental illness does not mean so-called insanity. Mental symptoms are frequently part of the picture in typhoid fever, puerperal conditions, autointoxication, and results of poisonous substances taken from without into the body.

3. Psychiatry and psychiatric nursing deal with the individual as a whole rather than with some particular organ.

4. The final analysis in every case, whether it be medical, surgical, obstetrical, or what not, has a mental aspect which needs to be taken into consideration.

   a. The suicides of chronic invalids.
   b. The marked depression seen in cardiac and nephritic cases.
   c. The exaltation of the hyperthyroid cases also seen frequently in tuberculosis.
   d. The delirium of typhoid fever.
   e. The confusion and mental deterioration seen in brain tumors.
   f. The hallucinations seen in toxic conditions.

These are all part of the picture produced by the inevitable mixture of mental and physical conditions.

5. The mental atmosphere of the home can be best studied by the nurse. It is she who comes into most intimate contact not only with the patient and the immediate members of the family, but frequently she acquires a most intimate knowledge of the patient's personal life including his worries, anxieties and the problems which he has to meet. With training pertaining to the mental health of patients the nurse can render reports which would be invaluable to the physician or surgeon in his task of making differential diagnoses. Hysteria, for example, may assimilate any symptom from the category of medicine and it is only after a long period of observation by one who is familiar with mental reactions that these symptoms can be intelligently interpreted.

6. I do not appeal to you to enter the field of neuropsychiatric nursing on the basis of any altruistic motives nor do I hold out at this time any economic advantages which might result by entering this field. Rather would I lay stress on the fact that it is your duty as members of one of the noblest professions to neglect no opportunity to fit yourselves to render the best that is in you. Without knowledge of the mentality, personality and individuality of your patient this cannot be done. You are being deprived of an opportunity to determine for yourselves whether or not you have a special interest and leaning toward psychiatric nursing and you are also deprived of the reward and the satisfaction that comes from success in nursing a damaged personality back to health and happiness.

There are two requisites in a superintendent (of nurses): 1. Character and business capacity. 2. Training and knowledge. Without the second, the first is of little avail. Without the first, the second is only partially useful; for we cannot bring out of a person what is not in her."—Florence Nightingale.

ENTERING THE PROFESSION OF NURSING

May I now address a few brief remarks to you, the graduating nurses of the Springfield General Hospital, who will be admitted tomorrow to the real responsibilities of the independent practice of your profession? You have heard flattering statements about the fitness of women for this important work. You have been culled and eliminated by a careful natural selection until only the fittest of your original class remains. You have withstood the strenuous drilling, the exacting routine, you have become educated in the fundamentals of scientific medicine and the art of caring for the sick. You have been subjected to the example of efficient and ethical teachers. You have learned by long hours of work under trying circumstances to govern your own desires; to hold in abeyance a tactless tongue and possibly an ungovernable temper. You have watched from the sidelines the many developments of the follies of human nature, the struggles of poverty and the depths of moral depravity. You have been in the midst of tragedies, of adventures and of romances. You have seen death and hopeless sorrow and you have seen the ecstatic joy of the mother at her new born babe. As I enumerate this list, in the minds of all of you are reenacted scenes and experiences that would fill a volume of the most transcendent material of romance and adventure, the knowledge of which must surely build the strongest characters.

This knowledge and this experience have been gained under the guidance of anxious and conscientious teachers, who have ever been able to advise and to assist.

The period of probation is now over. You are at the first altar and, like the bride, you have before you the responsibilities of real life, and it is for better or for worse.

Remember that knowledge brings responsibility and that experience makes or breaks one's character.—Extract from a graduating address delivered at Springfield (Mass.) General Hospital by Franklin H. Martin, M.D., Director-General, American College of Surgeons.

LEAVES AKRON CITY HOSPITAL

H. G. Yearick has resigned his position as superintendent of the Akron (Ohio) City Hospital. He relinquished his duties on September 1. Mr. Yearick went to Akron in May of 1919 from Spokane, Wash. where he was superintendent of St. Luke's Hospital. During his regime, a new pavilion was added to the Akron City Hospital, increasing the capacity of the institution to 225 beds, and the hospital was recognized by the American College of Surgeons as a Class A institution.

"A nurse should do nothing but nurse. If you want a charwoman, have one. Nursing is a specialty."—Florence Nightingale.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

POPULARIZING THE USE OF CERTIFIED MILK*

BY FRANK HOWARD RICHARDSON, M.D., CHILDREN'S DEPARTMENT, BROOKLYN HOSPITAL, BROOKLYN, N. Y.

IT WAS brought home recently to the members of the Milk Commission of the Medical Society of the County of Kings, New York, that their whole duty had not been accomplished when they provided the community with a healthful milk, and certified to its healthfulness. They came to feel that they owed it to the community to spread this knowledge much farther than it had ever yet been spread.

Accordingly, a special committee was appointed recently and charged with the task of bringing about a wider use of certified milk. The committee promptly reported its conviction that the only way to accomplish this aim was to popularize the prescription of certified milk by the physicians of the borough. The dealers, as all of us know, have always asserted that the sale of certified milk depends upon its prescription by the doctors; so that this report embodied no new discovery. It did seem worth while, however, to try to analyze the psychology underlying the peculiar fact that people need a doctor's prescription to persuade them to buy the best grade obtainable of the most important item in their dietary, when these same individuals would never for a moment consider buying second grade butter, eggs or meat.

There seemed to be two points of special interest in this connection. The first was the fact that the term "Grade A" seemed to most people to imply that the milk they were purchasing was of the highest grade obtainable; and that "certified," as it could not be better than the best, must be some fancy or specially processed milk that was of use only for a special purpose, such as infant feeding. The second point, which was believed to have some bearing upon the situation, was the fact that milk is as a rule paid for separately and not included with other items on a butcher's or grocer's bill; and so its price is a matter of universal knowledge. Then too any change in the price of milk is considered matter for newspaper comment.

Must Educate Doctor First

Our task then seemed to narrow itself down to educating the doctors to use certified milk and to order their patients to use it, not only for babies and for sick people, but for well individuals as well. For whereas many doctors, and probably most of the pediatricians, are already prescribing certified milk for their babies, sick or well, it is well-nigh unheard of for a doctor to urge the use of this grade of milk for healthy adults, irrespective of the economic financial status of the family in question, or to explain to his patients the simple readjustment in the daily dietary whereby this milk could be used at a saving rather than at additional expense, by cutting out superfluous amounts of meat and egg proteins, for instance.

Educating the doctor, however, is not always the simple task that it may seem at first blush. We conceived the task as having two distinct parts. One was to convince the physician by direct explanation, argument, appeal, demonstration—what you will; in other words, to proceed against him by means of a frontal attack. The other was to advance upon him from the flank; or, to change the figure, to hit at him from over the shoulder of his patients. For today a successful campaign of propaganda to reach the doctor must have two distinct phases—one medical and one lay. The latter was designed not primarily to convince the layman that he ought to use certified milk for his own table, for this never yet has been accomplished, but we desired so many laymen to make inquiries of their doctors on the subject that the latter would have to take notice and would be especially open to the direct educational appeal we planned to make.

It had been found in the past that the big certified milk meeting, advertised as such, was rather apt to fail of its purpose. Many men were repelled rather than attracted by the announcement of such a program, even when pictures and "movies" were announced. They feel that they will be regaled with pictures of prize cattle, and stables fitted with the latest fads in tiled walls and individual drinking fountains, and that they know beforehand quite as much of this sort of fancy dairying as they need or care to—and this is quite often a pretty fair diagnosis of such an evening's program.

Accordingly, in the new offensive a different plan was evolved. This consisted first in getting each member of the commission to arrange either for a paper or for a whole evening's program before as many of the smaller medical societies in town as he could approach through any personal connections. These included such organizations as the special societies; the local or neighborhood societies (of which there are a number in the large area covered by our borough); the hospital alumni or ex-intern societies; the medical fraternities; and, of course, the Pediatric Society and the County Medical Society. In

*Read before the American Association of Medical Milk Commission, at the annual meeting held in connection with the annual convention of the American Medical Association at St. Louis, May 22.

order to make these programs or papers as attractive as possible and to avoid the trite and obvious, emphasis was put, for example, upon the value of raw milk in nutrition; the importance of common cleanliness in the food supply; the vitamin theory, its history and its present status; the newer knowledge of nutrition with some of the fascinating work in feeding experiments that have gone to make it up; etc. The nigger in the woodpile in each instance was, of course, that the only way in which one can get clean, fresh, raw milk in our city is to get certified milk.

To drive home the points that might come up in the course of the discussion, as well as to answer with technical correctness some of the hard questions that we hoped might be asked, it was suggested that the expert of our commission be invited to all such meetings, and that at each there should also be present enough of a "claque" from the commission to stimulate a healthful and helpful discussion in case such artificial stimulation seemed necessary in order to make things "go."

A corrollary to this program of presenting papers is of course their publication in the local medical press, thus spreading further the message that in the nature of things has a fairly limited hearing in the proportion of the society memberships represented at the meetings.

The next means of approach consisted in getting members of the commission personally to stress, in all their work, both hospital and private, the use of certified milk in all conditions and upon all occasions. Of course, all the members of our commission were already using it, either largely or exclusively, in their own homes. But all found that even among their own patients there were many individuals upon whom they had failed to impress the fact of the overwhelming superiority of this grade of milk over the best grade of pasteurized available.

The pediatrists, who constitute the majority of the membership of our commission, began to find that, while many or most of their bottle-fed babies were on certified milk, it was almost the rule for their mothers to discontinue its use of themselves as soon as they dared; in most cases, as soon as mixed feeding was commenced, or shortly thereafter. A very simple statement of the facts in the case was almost always sufficient to make such parents go back to the use of the better grade of milk. The most effective argument here proved to be that there was no reason that their children should receive milk of a second class or grade, when they were getting eggs, butter and meats of the highest quality. Occasionally it was necessary to explain that even though the milk formula was to be boiled, it was none the less desirable to use the cleanest possible milk to begin with; and that boiling, although it could render a living germ harmless by killing it, could not make dirty milk clean nor supply a vitamin lacking through age of the product.

Prescribing It as a "Spring Tonic"

In consultation work, a simple recommendation of certified milk, with one or two reasons for its prescribing in the place of so-called "tonic" or "alterative" has usually accomplished two things. Of these, the lesser has been the resultant use for the individual case in question. The greater has been the impression made upon the mind of the family physician of the importance laid by the consultant upon its use, and his determination to recommend it himself as an important part of the treatment of future cases of a similar nature.

Recommending its use in hospitals or other institutions has been more or less limited by the very nature of the case; through the suggested supplying of institutions in cans, instead of in bottles, is a possible way out of this difficulty. Private room patients, of course, can always buy it as an outside item, just as fruit and special dishes are frequently brought in. Lactating mothers in maternity services especially fall under this heading. As Brooklyn Hospital pediatrists prefer certified human milk to certified cow's milk, however, we never recommend its use in any other way—in the feeding of the new-born—than by way of the mother's milk-forming laboratory.

The lay propaganda was organized similarly to cover as wide a field as possible with the realization that its value was to consist not so much in the direct education of the laity at whom it was ostensibly aimed, as in stimulating them to ask questions of their individual doctors. We knew that if this could be accomplished on a large enough scale, these men would be forced in self defense to familiarize themselves with the *status praesens* of the milk situation in the vast metropolitan area in which we live with its peculiarly difficult problems in the matter of purveying milk.

Needless to say, it was not considered wise for very obvious reasons to stress the rather unappetizing details of the production of even the best of pasteurized milk within the area of 100 miles surrounding us from which we draw our supply of milk. None of our commission members felt either wealthy or pugnacious enough to stand the brunt of a suit for libel, as the result of too realistic a discussion of some of the sights that greet the eye of any one looking over the ordinary type of farm, and the commission itself did not consider its funds ample enough to provide protection for any daring member who might have cared to be too vivid in his portrayal of conditions. Besides, there was the very natural unwillingness to anything that might discourage the use, on the part of the public, of any sort of reasonably decent milk, especially if such discontinuance of the use of relatively poor milk were to mean not its replacement by a better grade, but simply a stopping of milk drinking altogether. And, as Dr. Van Derslice said in a paper before this body in 1915: "In furthering the use of certified milk there is and should not be any attempt at climbing up by the pulling down of the commercial product. Certified milk sells itself by its own excellence and superiority."

The simplest means employed in the lay propaganda consisted in explaining to friends, even though they chanced to be patients of other doctors, the advantages inherent in certified milk. Any physician is occasionally asked to recommend a "spring tonic," or "blood purifier," whatever either of these may mean. Certified milk, with two or three reasons therefor, constitutes an excellent answer.

The next means consisted in the utilization of opportunities constantly being presented for health talks in churches, schools, chautauquas, lecture courses, etc. Most doctors feel it a duty to do their share toward the education of the laity in matters of disease prevention and health promotion, and the importance of the best grade of milk obtainable is one of the points that always needs stressing. The members of the commission consider themselves fortunate in having been able to give a great many such talks in the course of the year. Our local Red Cross chapter has for one of its activities the promotion of such health education and maintains a speakers' bureau whose sole object is to put various agencies throughout the community in touch with men who are willing to give health talks. To show that we are quite up to the minute, we need only add that two of our members have been asked to "broadcast" health talks from WJZ, the Newark

station of the Westinghouse. Embracing this opportunity to spread the gospel of certified milk via the ethereal waves, one of them took "Nutrition" while the other elected "Child Welfare." Needless to say, each did his duty by certified milk in such topics as these. We must confess, however, that so far we have not availed ourselves of the opportunities lying open to us in the illuminated sign, nor have we subsidized the public press to popularize our product. We have however not despised the power of printer's ink; for each month a reminder card goes out with the County Society's notice of meeting, with some catch phrase or appropriate legend bearing on certified milk.

In both these campaigns, there were two "talking points," if you will allow the expression, that were specially stressed. The first was, that milk is by all odds our most important food—the only article of diet that may honestly be called indispensable. McCollum has put this more convincingly in his little book, "The Newer Knowledge of Nutrition," than it can be found anywhere else. He shows that it is practically the only food for which no acceptable substitute can be provided with safety. The other point was, that there is nothing wonderful or far above the ordinary in the requirements governing the production of certified milk, that these requirements, in short, are really minimum rather than maximum for the production of an ordinarily safe milk. We have been putting our emphasis, unwisely I believe, upon the wonderfully *de luxe* accommodations provided for the fancy certified herd—the tile or porcelain-lined stables, the individual drinking cups, etc. This particular "selling talk" has gone sadly wide of the mark in convincing the great mass of families comprised in the class that we have wanted most to serve—the class, that is, that considers their children so important that they are willing to make any *necessary* sacrifice to provide the best for them. *Necessary* sacrifice, mark you; and they are inclined to consider not as necessary, but as freakish costly fads, some of these refinements and frills that we have been inclined to dwell upon in some of our talks.

The point that we have agreed upon as best suited to bring about an increased consumption of certified milk has been this: That certified milk is nothing more nor less than milk produced as any decent man or woman would wish to produce it for his family and his guests, if he were himself the owner of one or two cows. And conversely, that no other grade of milk, whatever letter of the alphabet be used to designate it (and Grade A does *not* mean Grade 1, in New York City at any rate, in spite of the fact that most people think that it must), *is* so produced. What are these very matter-of-fact requirements, that any individual would expect to carry out himself?

1. Cleanliness—clean cows, clean udders, clean utensils, clean hands of clean milkers dressed in clean clothes.

2. Freshness—milk to be delivered to the consumer within twenty-four hours of its production.

3. Health—healthy (non-tuberculous) cows, milked by healthy (non-venereal and non-typhoidal) workers.

4. Sweet-taste—the only milk decent enough to be allowed by law to be sold without some processing or other which alters the taste.

If there is no one of these points which a parent would not consider a minimum requirement—which he or she would be willing to dispense with—then a product which fails in any one of these is not a fitting food to be used on the home table. But we know that in order to cover these minimum requirements it is necessary to buy certified milk for any other grade falls short, not in one of them, but in several.

Such, in very brief form, are some of the ways in which the milk commission of the Medical Society of the County of Kings has sought to carry out one phase of its duty to the parent society and the community which it serves, namely: that of spreading the gospel of raw, clean, fresh milk throughout that community; and especially throughout that key group, the members of the medical profession. It is hard to estimate what effect this effort has had upon the sales of certified milk; perhaps such an estimate can never fairly be made. But we do know that the word spoken into the air is never absolutely lost, and we confidently believe that even such an unostentatious but persistent campaign as the one that has been outlined cannot fail to accomplish great good to our constituency. Whether a more extensive campaign shall be entered into later, has not yet been decided.

NEWS ITEMS

Dietitians of Ohio have planned meetings for December 6 and March 7 as a part of the coming year's activity in that state. Officers who will lead the Ohio Dietetic Association, organized last October, were elected at the meeting at Dayton, May 9 to 10 as follows:

President, Miss E. M. Geraghty, Lakeside Hospital,

OFFICERS OHIO DIETETIC ASSOCIATION

Above are the new officers of the Ohio Association: Miss Geraghty (upper left), Miss King (upper right), Miss Willson (lower left), and Miss Hyde (lower right).

Cleveland; vice president, Miss Jessie King, Grant Hospital, Columbus; secretary, Miss Irene Willson, City Hospital, Akron; treasurer, Miss Bertha Hyde, City Hospital, Cincinnati.

The following committees have been appointed by the new president of the Ohio association to serve for the coming year:

Program: Chairman, Miss Lulu Winans, City Hospital, Youngstown; Miss Florence Smith, Children's Hospital, Cincinnati; Miss Emma Eggert, Lakeside Hospital, Cleveland.

Membership: Chairman, Miss Sarah Benedict, Miami Valley Hospital; Miss Margaret Plough, Tuberculosis Sanatorium, Cincinnati; Miss Irene Willson, Akron.

Nominating Committee: Chairman, Miss Sara McInnis, City Hospital, Springfield; Miss Florence West, Peoples Hospital, Akron; Miss Bess Gatton, City Hospital, Mansfield.

Cook Book is on Press

The cook book which has been compiled by the Chicago Dietetic Association is being published by the Macmillan Company under the title "A Book of Recipes." The committee has been at work for a year on the book and it is said to be most original in make-up. It will be off the press, according to plans, in time for the annual meeting of the national association in Washington, D. C., October 16-18.

The Chicago Dietetic Association has recently received so many calls for dietitians from hospitals and from dietitians for positions that it has authorized the appointment of a committee to act as a clearing house for such requests. Mrs. E. A. Fischer, 5458 Kimbark Avenue, is chairman of the committee and such requests are being addressed to her.

A field for dietitians is revealed in the recent report of the Jail Survey Committee of the Chicago Community Trust. The report which was curtailed both on account of the short time allotted to it and the limited time members of the committee had to devote to it points out the need of trained dietitians to provide an adequate diet at a minimum cost.

Following the discussion at the May meeting of the Chicago Dietetic Association, relating to the violations of a city ordinance regarding the covering of food in shops, a committee from the association has recently been named to call attention of the Food Inspection Bureau to such violations. Miss Ruth Chambers of St. Luke's Hospital is chairman and irregularities are being reported to her.

New Officers for Alleghany County

The Alleghany Dietitians Society held its annual meeting on June 21 at Mercy Hospital, Pittsburgh. The following officers were elected:

President, Miss Margaret Frotheringham, Mercy Hospital, Pittsburgh; vice president, Miss Emily B. Hall, Western Pennsylvania Hospital, Pittsburgh; secretary and treasurer, Miss Hilda Reinhold, Mercy Hospital, Pittsburgh.

Following the business meeting the society spent a pleasant social evening.

Course for Pupil Dietitians

Walter Reed General Hospital, Washington, D. C., is offering a course for pupil dietitians which promises to be exceptionally fine. The course covers a period of six months, during which time the pupils are given practical experience in the various messes and in the laboratory. Lectures for the Army School of Nursing, beginning October 1, are open to the students. Among these lectures are courses in diet in disease, physiology and anatomy, and communicable and occupational diseases.

Opportunity to attend some of the meetings of the American Dietetic Association which holds its annual convention in Washington, October 16-18, will be given. Arrangements will also be made for pupils to visit the various bureaus of interest in the department of agriculture, such as the bureau of chemistry, bureau of standards and the department of home economics. Quarters, subsistence and laundry are furnished the pupils, it is announced, in addition to a nominal salary of $15 a month.

Personal Mention

Miss Bertha Luther is administrative dietitian at the Children's Hospital, Boston. She has charge of the entire food service. Miss Luther was formerly at Cook County Hospital, Chicago. Her assistant is Miss Katherine Lees, who is a graduate of the University of Wisconsin and had student dietitian training at Massachusetts General Hospital.

Miss Margaret Frotheringham, Miss Laura Ober and Miss Kate Helzer, members of the Dietitians' Society of Allegheny County, attended a summer school at Columbia University.

Miss Emily B. Hall recently accepted a position as chief dietitian at the Western Pennsylvania Hospital, Pittsburgh. Mrs. Helen Chase Barcalow accepted the position as assistant dietitian formerly filled by Miss Hall.

Miss Mary L. Rhoads gave up her work at Coatesville Hospital, Coatesville, Pa., to accept the position as dietitian at the Tuberculosis League Hospital, Pittsburgh,

Miss Mary Louise Shaw has been appointed dietitian at the Nassau County Tuberculosis sanatorium at Farmingdale, L. I.

Miss Caroline Kling has resigned her position at Grace Hospital and has accepted a post as dietitian at Hotel Statler, Detroit.

CHICAGOANS ISSUE BIBLIOGRAPHY

The publicity committee of the Chicago Dietetic Association has issued the following bibliography which will be of interest to all dietitians:

Gillett, Lucy: The Great Need for Information on Racial Dietary Customs. Journal of Home Economics, 258 (June) 1922.

Kuh, Dr. Sidney: The Diet of Nervous Patients. THE MODERN HOSPITAL, 18, 457 (May) 1922.

Sale, H. W., and Skinner, W. W.: Food Flavors: Their Source, Composition and Adulteration. American Food Journal, (May and June), 1922.

Gulick, Addison: A Study of Weight Regulation in the Adult Human Body During Average Nutrition. American Journal of Physiology, (April) 1922.

Berea College Where Every Student Must Work. Hotel Monthly, 34 (June) 1922. This is an exceedingly interesting article showing how the study body helps to support itself. The organization of the food department is very much worth the time of dietitians.

Westlake, William: How to Feed in Summer Camps. School and College Cafeteria, (June) 1922.

Feeding Students for the Priesthood. School and College Cafeteria, (June) 1922. Shows the problem involved in diet in a Catholic preparatory school.

Funk: Dr. Casimir: Science Can Make Margarin Richer than Butter. American Food Journal, (June) 1922.

Lister, Dr. James S. U.: The Influence of Rigid Salt Restriction in the Diet of Chronic Nephritis. American Journal of Medical Science, (June) 1922.

Hardt, Dr. Leo L. J.: Studies of the Cause of Pain in Gastric and Duodenal Ulcer. Archives of Internal Medicine, (May) 1922.

Prof. Raymond Pearl of the U. S. Public Health Service has discovered that both the suddenness and the destructiveness of the first flu epidemic coincides significantly with the normal death rate from heart diseases in many American cities. It does not so coincide with the death rate of any other important disorder. The inference is obvious.

Hospital Equipment and Operation

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

MARKING GOODS IN A HOSPITAL LAUNDRY

By WALTER T. WILLIAMS, Cincinnati, Ohio.

RESEARCH in hospital laundries indicates that a little more attention given to the marking department, with the introduction of system, would save much time and prevent many errors with their resultant confusion. It seems that there is no standard system of locating the identification marks, and it seems that there is no logical plan of assigning marks to persons. In other words, the mark on a personal article may be a name, two or three initials, a series of figures, or a combination of letters and figures; and on a given kind of article this mark may be found one time in one location and another time in a different one.

The marking, as a rule, is either done by a marking machine or by a stamp or stencil, so there is no necessity of discussing the old, slow method of pen-marking. Persons who can mark goods with a pen are so few that even in a small plant a marking machine is necessary.

Use Marked Tapes

In the Cincinnati General Hospital, as told in a previous article, the marking of individual pieces, or personal articles, is done by the respective owners, with the exception of the interns. Each person is given a supply of marked tapes, and these tapes must be sewed on the pieces, in a prescribed place, by the owner. As this plan works well in one hospital, there is no reason for it not working well in others. In order to effect the greatest possible saving of time, if this plan is adopted, one should be sure to prescribe for each article a specific place at which the tape must be sewed.

There should be a specific location on a given article for two reasons: first, in order that when the bundle is opened up in the laundry's marking room, one may quickly find whether all articles bear a mark; second, in order that when the articles are folded the marks may be seen by the sorter. Sometimes it is necessary to place the mark on the under side of the goods, and in such cases it should be so located that the assorter has only to turn up the edge of the goods at a certain place to see it.

Motor-driven marking machine, from photograph taken in Christ Hospital, Cincinnati. This machine is located in the sewing room, where all marking is done. As the characters are one-fourth-inch high, it is not necessary to use a stamp or a stencil on any goods. "It is the most useful mechanical device in the hospital, and we could not get along without it," said the head of this department, who is shown in the picture.

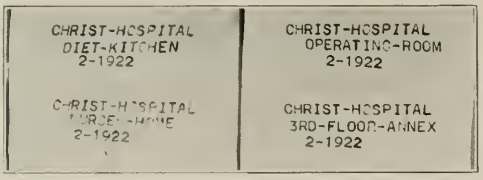
Adopt Schedule to Guide Markers

To be sure that all marks are uniformly located, there must be a schedule to guide the markers. Taking as a basis a marking plan that is used in many commercial laundries, and checking it up with the plan that is used in the Cincinnati General Hospital, I have arranged a schedule that can be used in any hospital laundry, large or small. It will do no harm to the general plan, however, if one sees fit to use different locations for marks, if the general idea of uniformity and accessibility is adhered to.

For convenience, the articles are listed in alphabetical order, regardless of whether they are personal goods or otherwise. While the list is very comprehensive, a few unusual pieces may have been omitted, but in this case one may with little difficulty easily determine a suitable place for the mark and add it to the list.

In case of dark goods, or where the fabric is too rough to take a mark, the mark should be made on a tape, placing it at the indicated spot. There is a special sewing machine for attaching tapes, and where this can be afforded it will be found a great convenience. As the marker can easily determine the cases where it is best to use a tape, I shall not dwell on that matter.

"Wrong side" and "right side," as used in my schedule, are trade terms which respectively mean the side of the goods which is worn on the outside and the side of the goods which is worn on the inside. In the case of flat work the terms refer to the side which is visible and one which is not.

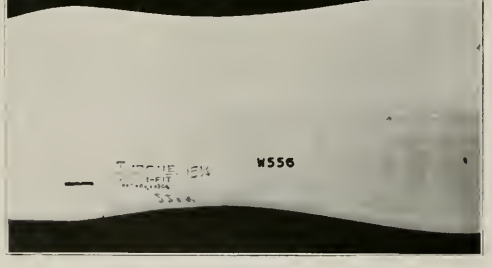


Some of the marks that are used in Christ Hospital, Cincinnati. The mark is placed directly upon white pieces and a label is marked and attached to the dark goods. The letters are one-fourth inch high.

Marking Schedule

Aprons—wrong side, on band.
Bath robes, individual—wrong side, at neck.
Bath robes, patients'—at left breast, right side.
Bags—top, wrong side.
Bed ticks—at opening, at seam, wrong side.
Bed gowns, patients'—on left breast, right side.
Bed pads—on corner.
Belts—in center, wrong side.
Bibs—on string, wrong side.
Blankets—at corner.
B. V. D.'s—shirts, at back of neck, wrong side; drawers, at back of band, wrong side; union suits, at back of neck, wrong side.
Coats—at back of neck, inside.
Coats, surgical—at right breast, wrong side.
Chemise and combinations—At bottom hem, wrong side.
Caps, nurses'—on string, wrong side.
Caps, doctors'—at hem, wrong side.
Collars—wrong side, near buttonhole.
Corset covers—at front, on band, wrong side.
Draperies—on corner, wrong side.
Drawers—near top button, wrong side.
Dresses—at back of collar, wrong side.
Dressing sacques and kimonos—at bottom, on button side, wrong side.
Fancy pieces—on corner, wrong side.
Handkerchiefs—in corner.
Napkins—on hem or selvage, wrong side, in corner.
Night shirts and night dresses—at top of back of neck, wrong side.
Operating linen, miscellaneous—on hem or selvage.
Overalls—trousers, on waistband, wrong side, near button or on pocket; jumpers, or waists, at back of neck, wrong side; bib garments, on bib, wrong side; one-piece garments, at back of neck, wrong side.
Pajamas—at back, wrong side, below draw string; coats, at back of neck, wrong side.
Pillowslips—on band, at opening, wrong side.
Hosiery—at top, over heel, wrong side.
Sheets and spreads—on wrong side, at corner, at left.
Shirts—The common method is to place the mark inside of the neckband, at the back. A method which facilitates the assorting is to place the mark on the outside of the neckband, next to the back buttonhole, for then the assorter can see all of the marks on a pile of shirts at one time.
Skirts—at placket, wrong side.
Tablecloths—on corner, wrong side.
Table pads—on corner, at left.
Towels, hand and bath—on corner, at left.
Tray cloths—on corner, wrong side, at left.
Underwear—shirts, back of neck, wrong side; drawers, on band at back, wrong side; union suits, back of neck, wrong side.
Vests—at back of neck, wrong side.
Waists, women's or children's—on button side, at bottom, wrong side.
Washrags—in corner.

The foregoing applies to machine marks and hand marks. In some cases, of course, very large marks are made in conspicuous places by means of a stamp or stencil, or marks may be woven into the goods as is sometimes done when towels are made. For instance,



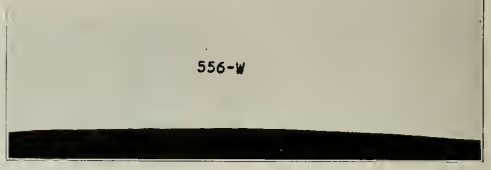
Starched collar with both a machine mark and a hand mark, freshly made, showing the difference in visibility of the two kinds of marks.

if there is a contagious ward, the linen from it will be marked "Contagious," in large letters. Sometimes it will be found convenient to mark linen with the designation of its ward, and in other cases the number of a floor should be used. The marking system, of course, must be in accord with the linen room's distribution system.

It is a good plan to mark on the linen, in addition to the usual identification mark, the date of its first laundering, in order to determine the life of the goods. As has been previously stated, the life of a piece of goods depends on several things, such as natural wear, wear and corrosion of the fiber in laundering, character of the fiber, kind of weave, damage by doctors, nurses and patients, and so on. It is well to find whether the fabrics are lasting a reasonable length of time, and then, if they are not, it is well to find whether the maker, the laundry or somebody else is at fault.

Marks Should Mean Something

Be sure that your marking plan is a simple one. Do not use persons' names or initials, nor abbreviations and combinations of meaningless marks and numbers. Let each mark mean something and not be a mere untrans-



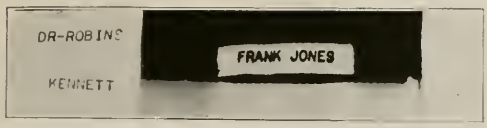
Soft collar, with a machine mark and a hand mark. Although both marks have had about the same number of washings, the hand mark has almost disappeared.

latable hierogylphic. Such marks as "B. E. M.," "Jones," "Brown-2," "W-562," and so on, are out of place in a hospital laundry. They may do well enough in the commercial laundries, and it may be necessary to use them there, but the use of such marks is neither logical nor economical in the hospital, except perhaps in the case of a sanatorium where it is necessary to do laundering for patients.

In most hospitals, each nurse has a number. In this case, the nurse's number and the designation of her quarters should constitute her laundry mark. Let us suppose that Miss Alice Brown, a nurse, is Number 27, and that she lives in the nurses' home, in dormitory A. In this case her laundry mark should be "27-A," a very simple mark that would tell the whole story.

The same system should be used for the personal washables of the interns and others. The laundry superintendent should secure from the office a list of the names, numbers and quarters of the nurses, interns and other residents of the hospitals. Then a mark record should be made up, assigning to each person a mark. A card index, arranged alphabetically, is best for this.

In some institutions, such as sanatoriums and convalescent hospitals where it is necessary to launder the goods of the patients, it may be desirable to omit permanent marks from the finer articles, especially those which belong to women. Some use marking pins, which

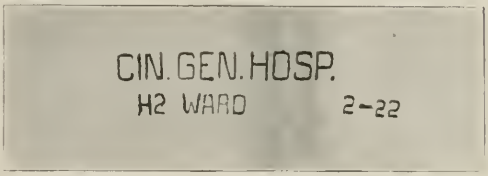


At the left is shown a doctor's mark and a nurse's mark, made directly on the goods. At the right is shown a tape mark sewed on a dark stocking.

are very large safety pins which have numbers on them, but as these are apt to tear the goods, they are objectionable. Here is a very simple plan for attaching a detachable tape:

Cut a piece of marking tape three inches long. Fold it in the middle. Place it in the proper position on the article. Sew the folded tape on the piece, making the seam but one inch long, so as to leave one-half inch of each end loose. One seam in the center will do, but a seam may be made on each side if desired. Mark the tape either before or after sewing it on. When the piece is laundered, the tape may be removed without damage to the goods by taking hold of each end and giving a quick pull which will break the threads of the seam. Do not use very strong thread. The folded tape may be sewed on one side of the goods, or one side may be under and the other over the goods.

A few illustrations are published herewith, showing the character of the mark and where it should be placed, and



Specimen of mark that is made by a stamping machine used in the Cincinnati General Hospital. The characters in the top line are permanent, these being one-half inch high. The characters in the bottom line can be changed, they being three-eighths inch high.

the legend under each explains it. My next article will show how articles should be folded, and incidentally will say more about the making-up of the marks and the positions in which they should be placed.

HOSPITAL SIGNAL SYSTEMS*

By E. NEWTON-WELLS, Signal Engineer, Chicago.

Grey Nunnery, Montreal, Canada—Destroyed by fire February 14, 1918. More than 50 babies burned to death.
State Hospital for the Insane, Norman, Okla.—Destroyed by fire April 13, 1918. Thirty-eight men and boys burned to death.
Hospital for the Insane, Columbia, S. C.—Destroyed by fire May 29, 1918. Ten patients killed and many injured.
Mercy Hospital, Big Rapids, Mich.—Destroyed by fire December 1, 1919. Five killed and three injured.

THE above mentioned hospitals were picked at random from the available records for the past twelve years as typical of several thousands.

If fire protection is warranted in our hotels, factories and schools where physically fit occupants are the rule, how much more necessary is it in institutions used twenty-four hours of each day and filled with the sick and helpless?

The records show that one hospital burns each day, half as many similar institutions are damaged or destroyed each week and the lives of the sick, crippled, blind, and new-born are snuffed out singly, in small groups and occasionally by the score. Nurses bravely risk their lives and remove helpless patients; Sisters of Mercy face death to rescue their charges—these acts prove the heroism of which men and women are capable. The necessity for such bravery lies largely in ignorance, carelessness and criminal disregard of the fundamentals of fire prevention and fire protection.

It is gratifying to know that there are today many institutions which from a fire safety standpoint approach the ideal, but the number of truly safe institutions is small and in the majority of older institutions the conditions frequently are appalling.

The function of this article is to drive home the seriousness of existing conditions and to set forth a few essential facts regarding fire alarm signaling systems which will enable adequate and suitable protection if combined with fire prevention measures.

At all institutions fire fighting must come second to life-saving. In hospitals a safety corps should be organized composed of doctors, nurses and attendants. The duties of the safety corps should be to respond to all fire alarms, treat and control patients and remove them to places of safety when necessary. All members of the safety corps should be able to turn in a fire alarm properly. The alarm should be transmitted to the superintendent and engineer promptly in order that they or their assistants may use extinguishers on incipient fires, and if occasion requires summon the city fire department.

Because of the possibility of error and delay, the telephone method of sending in an alarm is unreliable and not approved by the Underwriters or the National Fire Protection Association.

Fundamentally the requirements of a hospital fire alarm signal system are much the same in one hospital as in another. Nevertheless, it has been learned by experience that existing conditions create such variations in the details of these requirements that no one particular type of system can be described that will cover the field in general. It is a safe rule where such a system is to be provided to call in a competent signal engineer to go over the institution and lay out a system suitable to the particular requirements.

No hospital building, either old or new, or however well constructed and equipped to resist fire, is immune from fire peril nor from the panic conditions resulting from an imperfectly managed system of removing the patients from the building.

This statement applies to all types of buildings including the modern (so-called fireproof) buildings. Fires among the contents of such buildings have been known to create in a short space of time sufficient quantity of gas and smoke to start a serious panic.

Generally speaking, a modern fireproof building is fireproof so far as the building itself is concerned and would be as difficult to consume in a fire as a modern furnace, but it is possible to have a very hot fire in either. Therefore, the safety of the patients and staff of a hos-

*This article dealing with fire alarm systems is the third in a series on signal systems written for The Modern Hospital by Mr. Newton-Wells.

pital building is not guaranteed by the fireproof construction of the building or by means for extinguishing fire, but rather in well arranged exits, efficient training of the safety corps to the end that a small blaze may be quickly extinguished without alarming the patients, or if occasion arises the removal of the patients without confusion or panic.

A study of many hospital fires in the past will show that in many cases the loss of life has been due as much to panic as to the fire itself. Panic conditions are frequently the result of delays in transmitting the alarm and the lack of training of the hospital staff for such emergencies. Panic, destruction of buildings and a heavy death toll may often be prevented by providing well arranged exits, means for extinguishing fire and a systematically trained staff—these things, in my opinion, are best accomplished where modern fire alarm systems are in use.

Fire Alarm Signals

Fire alarm signals should be so given as not to alarm the patients unduly. In many cases it is well if patients do not know that a fire has occurred. Boxes should be located at advantageous points throughout the building, and gongs so placed as to be heard by officials and members of the safety corps.

The system should preferably be of the approved closed circuit fully protected and supervised type, arranged so that an alarm sent in will notify the officials without sounding gongs throughout the building to alarm the patients. This is usually accomplished by the breaking of a glass in the door and pulling the lever down.

Boxes should be fairly large and with semi-flush mounting which are readily seen and their location easily fixed in the minds of the staff. (Small flush type boxes are not to be recommended.) The mechanism should be substantially made, embodying non-interfering dual signal code features.

Boxes and gongs should be on separate circuits connected to the control panel. The control panel should be so arranged that all boxes and gongs are constantly under electrical supervision so that the slightest interruption to the electrical current, or any disarrangement to the box or bell circuits, will immediately cause an alarm to be sounded on the trouble bell located on the control panel. The control panel should be equipped with necessary voltmeters and ammeters in order to ascertain the condition of the circuits and electrical current at all times. The power used for operating should preferably consist of one or two sets of storage batteries charged from the lighting circuit, and should be of sufficient size and capacity to insure the operation of the system for at least twelve hours in the event of failure of the lighting circuit.

When an alarm is sent in from one of the boxes it should be received in code form on a punch register and tapper bell located in the superintendent's office and engineer's quarters, the code giving a definite location of the box pulled. Upon responding to the alarm if the fire is found to have gained such headway as to warrant the calling of the fire department, the door of the box is opened, which action automatically connects the private alarm system with the city system; pulling the lever down with the door open sends an alarm to the fire station and repeats the local alarm.

The necessity of notifying patients when fire is discovered will depend largely upon the seriousness of the fire and the character of the patients. All fire gongs intended for use when the sounding of a general alarm becomes necessary should be arranged so as to function only when set in motion by authorized parties, either from any one of the many boxes equipped for dual signaling or by means of a manually operated code signaling device located on the control panel. Where more than one building is involved the signals should be transmitted only to the building in which the fire has taken place, so as not to cause panic conditions in building not affected or in danger.

Open Circuit Systems Not Recommended

Open circuit fire alarm systems are not so satisfactory. They are unreliable and depend upon constant testing to insure their operation when required, and it is at such times that they are usually found to be inoperative owing to wires being broken, available current cut off, or batteries low or dead. Closed circuit systems are constantly under electrical supervision, maintained by a small amount of current derived from the battery constantly flowing over the circuits. An interruption to this current or the circuits over which it flows upsets the normal conditions and causes the operation of devices at the panel control board which in turn sounds the trouble alarm.

The operation of fire alarm equipment in hospitals and similar institutions from power derived directly off the lighting circuit is not the best engineering practice for the very particular reason that should an interruption occur in the lighting current the fire alarm system immediately becomes inoperative and useless. The use of open circuit fire alarm systems and systems operating directly from the lighting circuit is not approved for hospitals by underwriters. The N.F.P.A. permits of a current supply through the regular electric light system where it is acceptable to the local inspection department.

All such installations should be made in conduit to conform to the underwriters' rules and regulations. An improperly installed system is oftentimes worse than none and may even increase the fire hazard.

Set aside one day, Mr. Superintendent, to go over your building thoroughly from basement to roof, see to it that there is no accumulation of combustible material, check your exits, examine your extinguishers, ascertain if you can signal for the fire department other than by means of telephone; if you have not organized a safety corps, do so. If your institution is not equipped with a modern alarm system take it up with your board. You owe it to your patients. Let us hope that there will be less disastrous hospital fires in the future.

In speaking before the National Methodist Hospital and Home Association, Mr. Ralph Welles Keeler, director of publicity of the hospitals and homes of the Methodist Episcopal Church, said: "A great deal of leaflet and booklet publicity fails to be useful because its set-up is bad. Superintendents of hospitals or homes are not necessarily good judges of publicity or printing. Get a little advice. Study your own attitude toward printed matter that comes to you. Examine a type book. Remember that what you print you want read. As for half-tones or cuts, use only those photographs that tell a story. Oh, the miles of wooden pictures with which some are trying to illustrate the activities of institutions! Have your half-tones made a screen suitable for the paper on which they are to be printed. If possible use paper that will take an average screen, so that the half-tone can be used for more than one job. It may serve for the annual report, for a program, for the press, and for a leaflet."

THE ability to perceive what constitutes true excellence is most often seen in those whose powers of perception have been whetted by comprehensive training and broad experience. It requires a keen and capacious mind to make the fine distinctions that are always contributive to correct decisions.

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Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

DEFENDING MY COMMERCIALISM IN OCCUPATIONAL THERAPY

By CHRISTINE NEWMAN, Head Aide, Howell State Sanatorium for Tuberculosis, Howell, Mich.

IN STARTING our occupational therapy department at Howell State Sanatorium, we had but a very small fund to exist on, so it meant I had to keep a close eye on the commercial side if we were to exist at all.

In looking about I have often seen good and precious labor put on the wrong article; I mean by that, an article that is not appealing to the general public because of its design. The misplacement of labor is very often the cause of poverty. A number of poorly selected articles, no matter how well made, would cripple financially any occupational therapy department, and, again, a number of well selected articles would contain just as much therapy and sell with a profit that would make any department self-supporting.

When I first came here, some of our women patients who had been in a sick room for months and were nearly exhausted financially, were putting days of labor on a crocheted cap which they would sell to their next door neighbor for the precious sum of one dollar. Here is where an occupational therapy aide may step in and give both a therapeutic and financial aid. Give that same patient one of the pretty articles in vogue today, and in the same time she will double her dollar and will receive more therapeutic value of the novelty and satisfaction of the work.

Both Money and Therapy Aim

There can and should be both money and therapy in the right article.

The first thing I try to do is to find articles the public wants. If the public wants it, it usually is pretty. Pretty things, as a rule, bring harmony. Harmony brings relaxation and relaxation, we all know, is a great factor in bringing about a cure. A beautiful room, a beautiful piece of pottery or even a little scene will bring a spark of peace to any of us. I often hear my patients say, "Why I sleep so much better and my appetite has improved so since I am doing occupational therapy!"

In running our department here, a patient makes one thing for himself and one thing for us. If he wants to keep his own article he may do so; if he wants to dispose of it, I sell it for him. The articles made for the sanatorium, of course, have to be sold for the maintenance of the department.

When a patient is sent to me from the doctor, I generally know what condition he is in; so I show him a number of things he may do for himself, things within his strength and capacity. He usually chooses something he wants and I think I can safely say there is therapy in making something you want and like. On the other hand, there may be monotony in making a second article of the same kind, for your want is satisfied and your enthusiasm for that article is gone; so I let that patient make something for me that I have need of. There may be a number of articles, corresponding in labor and value to that of his own. We usually find something he is just as enthusiastic about. (Articles made of dyed milkweed, such as trays, muffin stands, tea wagons and serving tables for breakfast rooms have been successful in every way). For therapeutic purposes an article made of milkweed contains many operations. If the institution is located in or near the open country the exercise of gathering the milkweed will be attractive to the patient. My patients gathered so much last autumn that I still have a supply. Then the milkweed has to be carefully peeled and dyed in gasoline and tube paint the desired color, and, when dyed, put in a fine layer on the article; then follows the processes of weaving, staining and shellacing.

I do not say that everyone likes butterflies and milkweed, but it has a wonderful appeal to the majority of people, and our articles sell as fast as we can make them.

Our muffin stand, which costs us $3.50 to make, sells fast at $15. Still a merchant having to pay for the labor could not sell it for less.

Labor of Sick as Valuable as Well

I have heard occupational therapy people say, "We sell our articles ten above cost." But, tell me, why should not the labor of an ill man be just as valuable as a well man, providing it is well done?

There is despondency in receiving less for your labor because you are ill, and the psychological effect upon a patient who feels that his effort is worth less because of his illness is anything but healing.

Bernard Shaw tells us we can live three thousand years if we think so. Personally, my wrinkles are beginning to appear, so I beg heaven protect me from such a calamity. But nevertheless much wisdom is put into

Adv. page 50

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EVERYWHERE hospitals are proclaiming their approval of the special packing of KNOX SPARKLING GELATINE in one and five-pound cartons.

Recognized by dietitians, physicians and food authorities as the standard of purity for over 30 years, this special packing of Knox Gelatine, in one and five-pound cartons, makes it additionally desirable for hospital use.

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the four famous words—"Thinking makes it so." So, first of all let's make our patients think "up" by having everything on the upward path around us. We can do so by putting much thought and care on our selection of articles.

In the world of merchandise, it is always the idea that sells, the inventor or designer being the "main spring." A manufacturing house with a clever designer, together with good management, is successful. A manufacturing house with a poor designer is not successful, because of valuable labor put on unsalable things.

An occupational therapy aide particularly needs clever things because she is too poor to put her valuable labor on things that will not sell. I know this sounds very commercial, but I still maintain there is just as much therapy in a number of salable things as in the same number of unsalable things, and I can do far more for my patients if my department is on paying basis.

Last week one of our patients had to go to the poorhouse. His condition was not such that he was able to support himself. Still since he had more than outstayed his time here, he had to make room for someone else. The last day he was working a little hard to finish a lamp. When I asked him what he was going to do with it, he turned and said, "Miss Newman, me no money. Fifty cents all. Me sell it." Fifty cents was all he had, and he was going to the poor house. A lamp is not easily sold in a day and I was afraid if he took it with him, not knowing how to go about it, he would sell it for less than its worth; so I spoke to Dr. Pierce about it and we found our department was able to buy it back from him. Thus the poor boy went away with, to him, a full purse.

In taking inventory, I find that our expenses the first ten months were $1,197.30. That includes my salary, which the first year was very small. Cash received on articles sold for the sanatorium was $818.35, that leaves $378.95 which it cost the sanatorium to maintain the occupational therapy department the first year.

The second year I feel confident will entirely pay for itself, as the first year of any undertaking is spent more or less in experiment.

PSYCHIATRISTS EMPHASIZE WORK IN OCCUPATIONAL THERAPY

At the recent American Psychiatric Association meeting in Quebec, occupational therapy was a prominent feature. An unusually fine exhibit of craftswork from American and Canadian hospitals was shown at the Chateau Frontenac. Much credit is due to the head aides who prepared the exhibition and to Dr. Henry I. Klopp and Miss Clara H. Offutt who made the plans and collected the materials. Nearly every article shown carried a large tag, on which was given very briefly a history of the patient. In some instances, poorly constructed work, representing the original efforts of the patient, was shown accompanied by a piece of craftswork accomplished later after practice and training.

Not only was the exhibit appreciated by the members of the association, but large numbers of the townspeople of Quebec came to see what could be done by patients in hospitals for the insane. These persons got a new idea of hospital life, and it was evident that such exhibitions, when properly advertised, go a long way toward educating the public to the advantages and possibilities of occupational therapy.

The O. T. round table dinner was well attended, and the subsequent discussion lasted until almost midnight. Dr. Horatio Pollock, state statistician of New York, read a significant paper in which he stated that there should be one occupational teacher for every 100 patients in state hospitals and that such an arrangement would actually represent a hospital economy rather than an additional expense because the occupied and interested patients would require far less ordinary attendance.

Dr. McKenzie of Kalamazoo, Mich., said that the occupational therapy aide was, at the present juncture, better qualified than the attending physician to decide what the individual patient's occupation should be and how long it should be continued. He felt that the greatest immediate need lies in the education of medical men in the possibilities and limitations of occupational therapeutics.

Dr. F. E. Lawler of the Nova Scotia Hospital in Halifax expressed the opinion that even the insane should receive money or some other material reward for their occupational therapy efforts. He spoke of one patient who had done good work and who, when asked what he would like to have as payment, said that nothing would please him better than a bottle of whisky. The coveted reward was forthcoming, and Dr. Lawler assured the meeting that no harm came from the allowance.

The next annual meeting of the Psychiatric Association is to be held at Detroit, Mich.

O. T. EXHIBIT DRAWS INTEREST OF DOCTORS

An occupational therapy exhibit at the City Hospital of St. Louis was featured during the meeting of the American Medical Association. The graduation exercises of the St. Louis School of Occupational Therapy also were held at the City Hospital at this time. Not only were the workshops and school rooms in the City Hospital open to the visiting doctors, but a comprehensive display of the work of the students of the St. Louis School was on exhibit.

Occupational therapists were gratified by the large numbers of visiting medical men who thronged the City Hospital and School Exhibition, the Junior League Workshop and the occupational therapy department at Barnes Hospital. It was regarded as an index of the growing interest of the medical profession in occupational therapy. Several doctors stated that the occupational therapy activities interested them more than any other feature of the meeting.

THE ROLL CALL

Illinois

No new activities since the last report.

Manitoba

The annual meeting of the Manitoba Society of Occupational Therapy was held on June 1, when the following officers were elected for the coming year:

President, Miss E. A. Griffin; vice president, Mrs. J. P. Oliver; treasurer, Miss Jessie Stewart; secretary, Mrs. K. Stewart-Hay; board of management: Miss Hickie, Miss Buchanan, Miss Rice, Mrs. Wood, Mr. Warters.

At a meeting of the board of management held on June 12 it was decided to hold a large public meeting in the autumn, with a view to securing new members and extensive publicity.

It was also decided to give an educational course and a tentative scheme was briefly outlined and an educational committee formed.

Maryland

The Maryland Society for the Promotion of Occupa-

Adv. page 52

How nurses keep their feet in shape— ready for any task

Nature plans that the foot rest on heel, ball and outside *arch.*

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The Arch Preserver Shoe satisfies *both* Nature and Civilization.

THEY give their feet the "barefooted" advantages of foot length support by wearing the Arch Preserver Shoe. They keep their feet free from strain—free from discomfort. Thousands of nurses have found foot vigor by wearing the Arch Preserver Shoe; they have made their feet a real help instead of a handicap.

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We will send name of dealer or you may call the "Tel-U-Where" Bureau in your city.

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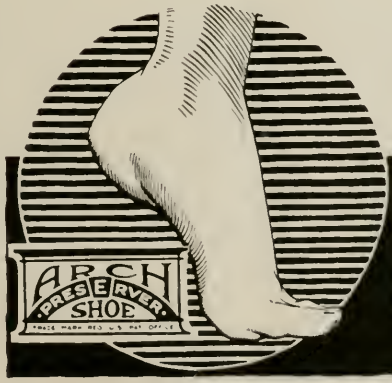

ARCH PRESERVER SHOE

tional Therapy met Monday, June 19, at the home of Dr. W. R. Dunton. The questions of registration, national uniform, pins or insignia, representation on the national society, and joint dues of the national and local society were discussed.

The meetings of the Maryland Society are discontinued during the summer months, but it is expected that the first meeting will be held in October as a joint meeting with the Maryland Medical Society.

Massachusetts

The Massachusetts Association for Occupational Therapy is continuing its policy of publicity meetings so that knowledge of occupational therapy may be furthered throughout the state.

A meeting was held at the home of Mrs. Henry G. Lord, Brookline, May 23 at which Dr. Joel E. Goldthwait spoke on "Occupational Therapy, What It Is and What It Does," and Dr. John D. Adams on "Occupational Therapy in Civilian Hospitals." This program was repeated at the Community House, Dedham, June 1.

Miss Robeson spoke on occupational therapy at the Bulfinch Street Church, Boston, recently, showing lantern slides; the lecture resulted in a generous contribution to the work from the Lend-a-Hand Society of the church.

Dr. Adams addressed the medical staff, nurses and trustees of the Burbank Hospital, Fitchburg, on June 8. A request for an aide and assistance in organizing an O. T. department resulted.

On June 15 Dr. Adams spoke at the nurses' graduation exercises of the Bishop Memorial Training School at Pittsfield.

The annual convention of the American Occupational Therapy Association at Atlantic City, September 25-28, marks a milestone in the growth of the association. It is the first convention in connection with the American Hospital Association and is in a sense a formal recognition of occupational therapy as a definite hospital department. This joint convention gives many advantages to occupational therapists, among them reduced railroad rates.

The American Hospital Association is able to offer us meeting rooms and exhibition space without any charge, but perhaps the best of the whole matter is the prestige which comes to our Society through this union of interests, says Dr. Herbert J. Hall. Occupational therapy is definitely a hospital function, and though our own meetings will be for the most part separate this arrangement will give us opportunity, as never before, to put our work rationally and logically before the hospital world. This Atlantic City convention should prove to be the best and largest in our history.

The complete program is printed in the supplement to this issue.

The Bureau of Occupational Therapy, now conducted by the Massachusetts Association, has moved into its new quarters at 443 Boylston Street, Boston. It is a corner shop on a busy shopping street and a great increase in public interest and sale of product is already evident. Consignments of finished occupational therapy output are coming from hospitals in Jamaica, Pennsylvania, Connecticut, New York, as well as from Massachusetts, and the Bureau has been recently in touch with aides and people desiring information in thirty-six different states. It is the desire of the association to make the Bureau a real and useful factor in the occupational therapy field throughout the country. The Bureau will buy materials and sell the finished product for any hospital.

Michigan

A meeting of the Michigan Association of Occupational Therapy was held at Newberry House on the second Tuesday in June. A picnic was given at Belle Isle for the Michigan association members and patrons on the last Tuesday in June. No business meetings of the Michigan Association of Occupational Therapy were held during the months of July and August.

Missouri

On May 10 the active members of the St. Louis Occupational Therapy Society abandoned their organization and became members of the Missouri Association for Occupational Therapy with an understanding that the occupational therapists by autumn would begin holding their monthly meetings for the mutual help and interest of the work. Dues were made one dollar per year. Thirty-one occupational therapists were admitted to the organization as active members.

The St. Louis School of Occupational Therapy (one of the activities of the Missouri Association) completed the lecture and craft course for its sixth class, May 22. Exercises were held in the St. Louis City Hospital where Dr. Harry E. Mock of Chicago and Mrs. Carl Henry Davis of Milwaukee gave illustrated talks.

Owing to ill health, Miss Alice H. Dean, head instructor of the school, and Miss Martha E. Gilbert, head instructor of the Shop for Handicapped, had to abandon their work with the organization in May.

Miss Idelle Kidder, director of the association, resigned her position in July for an indefinite rest after having directed its various activities for three years.

New York

Several thousand dollars were cleared at the recent Motor Truck Circus for the benefit of the New York State Association. Fred Stone thought of it in a hurry when the Occupation Therapy Society told him that it needed help to enlarge its work of rehabilitating ill and injured working men and working women. He sketched out the program of his Monster Motor Hippodrome and Wild West Show, and got the Lambs' Club, Tex Rickard, Keith's, National Vaudeville Association and others to promise to support him. Out of the impossibility of building a stage on the green in front of the fair grounds grandstand was born the motor truck plan—twelve trucks, each with a theater stage mounted upon it, to move in rotation before the audience, pausing at intervals to give its performance. No stage hands needed; no changing of scenery; just change the stage.

Twenty-two new members have been added to the New York Society.

A summer school of advanced classes has been conducted at Byrdcliff under the direction of Miss Zulma Steele and Miss Bodka Thompson.

Ontario

A publicity campaign was launched in June with various articles appearing in local publications. The funds for this campaign were raised at a garden party.

Adv. page 54

A Floor of Captive Sunlight

What could you find more appropriate for a sick room than a flooring which holds in itself the airy, golden spirit of sunlight?

Maple, varnished, gives you such a color. Its quiet cheerfulness finds response in the mind of the patient, and helps create the mood most favorable to recovery.

But beauty is only one qualification of Maple for hospital floors. It has unusual cleanliness, even when used bare and untreated in wards and hallways. The wood is so tight-grained and smooth surfaced that it has remarkably low absorbency and is easily cleaned. Its tough-fibred texture prevents slivering. Maple polishes under friction; this is the wood which outwears stone.

The quiet cheerfulness of a Maple floor finds response in the mind of the patient.

For Color—
BEECH AND BIRCH

Add the ruddy tinge of sunset to Maple's sunlit color, and you have the warmer tone of Beech and Birch. In wear these two woods are closest akin to Maple.

This trio of floorings offer you a range of service and color possibilities which meet the needs of hospital use, in private rooms, wards and halls, in office or kitchen — wherever wear and cleanliness is essential or beauty desired. Maple, Beech and Birch floorings— all three—are manufactured from the slow-growth, climate-hardened timber of Michigan and Wisconsin, and guaranteed in grade and quality by the trademark MFMA.

"Color Harmony in Floors"

—is the title of a book, just published, which will open interesting decorative possibilities to you. Ask your lumber dealer for a copy, or let us send you one with our compliments. For full technical information, and verification of Maple's wearing qualities, we refer you to your architect.

MAPLE FLOORING MANUFACTURERS ASSOCIATION
1065 Stock Exchange Building, *Chicago*

MFMA The letters **M F M A** on Maple, Beech or Birch flooring signify that the flooring is standardized and guaranteed by the Maple Flooring Manufacturers Association, whose members must attain and maintain the highest standards of manufacture, and adhere to manufacturing and grading rules which economically conserve every particle of these remarkable woods. This trademark is for your protection. Look for it on the flooring you use

Floor *with* Maple
Beech *or* Birch

Pennsylvania

The commencement exercises of the Philadelphia School of Occupational Therapy were held at the School, 2200 De Lancey Place, on June 8. The Rev. Dr. Jeffreys, rector of St. Peter's Church, made the opening prayer.

The dean, Miss Florence W. Fulton, spoke a few words in explanation of the work of the school, the type of student needed and the mission of the aide in the service.

Mrs. James Starr, Jr., president of the board of directors, presented the diplomas.

The Hon. Roland S. Morris, formerly U. S. minister to Japan, gave a stirring address in which he congratulated the school and the students upon being pioneers in this branch of the medical service. There were thirty graduates and of this number thirteen have already been well placed, positions have been offered to others, and it is hoped and expected that all will be placed before the autumn. The school has been very successful so far in placing all its graduates who desire positions.

Since the last report occupational therapy has been started at the Harrisburg State Hospital, Harrisburg, Pa.

At the request of Mrs. Slagle, the Philadelphia School of Occupational Therapy sent a small but comprehensive exhibition to Chautauqua under the direction of one of our graduate aides, Mrs. Barkley Johnson.

Washington, D. C.

No report.

Wisconsin

Miss Julia Hooker, a graduate of the Milwaukee-Downer College Training School, has accepted a position with the Junior League of Milwaukee. She will prepare designs for occupational therapists in the city and state and will be in charge of the paint shop and sales room.

Miss Grace Clapp, Ph.D., has been appointed director of the training school at Milwaukee-Downer College. Plans are being completed for the autumn classes.

REHABILITATION IN MASSACHUSETTS

THE federal government is holding out a helping hand to the states in developing another phase of conservation—human engineering.

Those who are physically disabled as the result of industrial or other accident or disease are no longer to be merely extended sympathy and to be forced to drift to the dead-ends in industrial and social life. Instead constructive efforts are to be made to assist them to utilize their remaining powers in the best possible way for their own independence, advancement and happiness, and the economic betterment of the community.

In a leaflet entitled "Vocational Rehabilitation for Persons Disabled in Industry or Otherwise," the Massachusetts department of education outlines the type of service which may be rendered. The leaflet reads:

"By an act of the Legislature approved by the governor May 25, and effective August 25, 1921, the commonwealth of Massachusetts accepted the provisions of an act of Congress whereby 'persons disabled in industry or otherwise,' and residing in the commonwealth of Massachusetts may be enrolled in vocational training courses planned for their vocational rehabilitation. For this purpose the commissioner and advisory board of education are constituted and designated as the state board for vocational education and directed to cooperate with the Federal Board for Vocational Education, and to establish and maintain, or to assist in establishing and maintaining, such courses as it may deem advisable and necessary.

"At this time it is held that the following persons are not eligible for this training:—

"Aged or helpless persons requiring permanent custodial care.

"Any inmate of a state institution, or any person confined in a correctional or penal institution.

"Any person deemed not susceptible of rehabilitation.

"Persons under the age of fourteen, and in some instances sixteen, years; or persons desiring courses in general education.

"Enrollment in and supervision of these courses will come directly under the rehabilitation section of the division of vocational education in the department of education.

"Upon application to the rehabilitation section persons disabled in industry or otherwise may receive any part or all of the following types of service:—

Counsel upon training for placement in the former occupation or a new one.

An opportunity to enter upon a suitable course of training: in trade, technical, agricultural, or commercial schools; by correspondence courses; or by placement in industrial or commercial establishments.

Supervision and guidance during training so that the greatest benefit may be derived therefrom.

Help in securing placement when the course of training has been successfully completed.

Advice and assistance in securing artificial limbs and other orthopedic and prosthetic appliances at minimum cost and inconvenience.

"Persons eligible for vocational rehabilitation under the provisions of this act should apply to the rehabilitation section as soon as possible after suffering the disability which incapacitates them for employment. They may apply in person, or the application may be made for them by an employer, an insurance company, a hospital, a physician, a social worker, a relative or friend, or by an interested citizen or agency. As far as possible persons interested in obtaining vocational rehabilitation but unable to come to the office will be visited at the hospitals or in their homes by an agent of the rehabilitation section.

"Under a plan approved by the governor of the commonwealth, the Massachusetts Department of Industrial Accidents is cooperating with the Department of Education in the administration of the above act. By this plan of cooperation persons injured in industrial accidents and eligible for vocational training are referred to the rehabilitation section.

"The cooperation and assistance of hospitals, medical associations, chambers of commerce, employers' associations, labor unions, social agencies, fraternal organizations, and other organizations of a like character are earnestly solicited.

"Applications received from any source will be considered individually and plans will be arranged which seem best suited to bring about the rehabilitation of the particular person.

"For further information concerning rehabilitation under the provisions of this act, persons interested may address or call upon Herbert A. Dallas, Supervisor of Rehabilitation, Division of Vocational Education, Room 212, State House, Boston 9, Mass."

Under the existing arrangement, the initiative remains with the several states. The federal government however through its Board for Vocationl Education encourages action by matching dollar for dollar the expenditures for rehabilitation made by the cooperating state.

Adv. page 56

They Tested Their CASTLE for accuracy

(The Hospital Superintendent and Surgeon were talking—Series III)

"*Good morning Doctor*"

"Morning. You know that new Castle Sterilizer—I like it. I was here yesterday when Miss Smith ran it. Apparently it's as good as they said it was. It will melt Diack controls anywhere in the dressings."

"*Right, we couldn't do that with the old one. I wonder if we were sterilizing at all.*"

"That's the question, but we certainly will now. The U. S. Bureau of Standards says that these controls don't melt until after exposure at 250° F.

"*Yes each of the six tests Miss Smith made was 100% positive. But Doctor, she's worried because there is no vacuum feature.*"

"Certainly *not*, that's the beauty of the thing. It's better to drive *all* the air out by steam pressure than to get a *fraction* of it out by vacuum. You know it is the presence of the air pockets that prevents sterilization. And the dressings come out dry, too. The steam jacket does that. I'm much pleased."

Write for Castle sterilizer specifications

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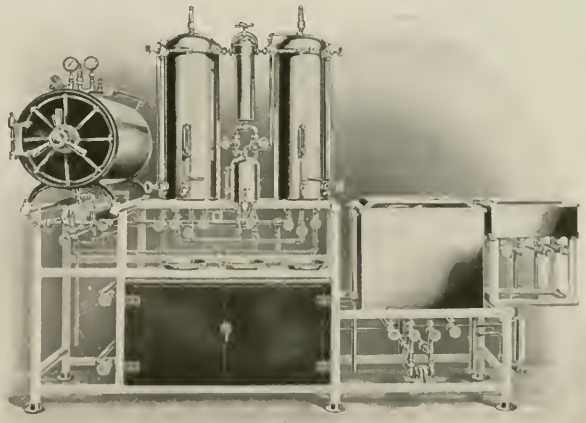

WILMOT CASTLE COMPANY, 1151 UNIVERSITY AVE., ROCHESTER, N. Y.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

VENEREAL DISEASE CLINICS IN THE CITY OF NEW YORK

MRS. Lesley Funkhouser's study of the venereal disease problem in the city of New York, a discussion of which appears in a recent issue of the *Journal of Social Hygiene*, discloses much interesting and valuable information in regard to venereal disease clinics.

The study was undertaken by the sub-committee on venereal disease of the Charity Organization Society, under the direction of Mrs. Funkhouser. It was approached from three angles: that of the venereal disease patients themselves as they appear under the care of the society; the facilities available for examination and treatment; and the existing legislation affecting the situation.

Clinics Are on Increase

The study of facilities for the examination and treatment of venereal diseases in the city shows an increase in the number of venereal disease clinics since 1919. The survey indicates that there are about fifty-five clinics and six hospitals available. Of these, thirteen clinics and two hospitals were selected for intensive study. They represent the best existing facilities at present for the examination and treatment of patients from the medical standpoint of the American Social Hygiene Association and the social standpoint of the Charity Organization Society. The data were obtained through interviews with the medical director of the American Social Hygiene Association and the executive officers and case workers of several social agencies; through the reading of case records of the society; and through visits to the clinics themselves and interviews with the head physician and social worker of each clinic. The study was confined almost entirely to that of the syphilis department of each clinic.

The following rules seem to be common to all of them:

1. Clinics are not restricted. Patients from any part of the city will be accepted without question.

2. No charge is made to patients who are unable to pay for treatment.

3. Wassermann tests are given direct, if so requested, without the necessity of having the patient pass first through the general medical clinic.

4. Wassermann tests are not taken as a routine part of the general medical examination.

5. Diagnoses can only be obtained by letter from the superintendent of the hospital, and as such, are considered strictly confidential.

6. Treatment is given in courses, and no patient is considered discharged for a period of at least two years.

The physicians estimate that an average of from 30 to 50 per cent of their cases discontinue treatment before being cured. But few of the clinics use the complement-fixation test for gonorrhea or the provocative Wassermann test for syphilis. All of the clinics claim to make daily reports of their infectious cases to the Department of Health, but the Department of Health is not used to secure compulsory treatment for such cases.

Weak Points in Clinics

The clinics investigated are located in all sections of the city. They are handling from 30 to 4,000 active cases each, according to the size of the clinic. Although steadily improving, they show the following weaknesses at the present time:

Lack of clinic space.—Six of the clinics have no provision for the separation of men and women. Four have separate rooms for each, and three provide for treatment of each sex on separate days. At best, the syphilis department of the clinic has at its disposal only two or three rooms and these rooms have to be used for both Wassermann tests and mercury and salvarsan treatments. Rarely are there separate rooms for examination and for treatment. There is also a deficiency of tables for salvarsan administration, most of the clinics having only one or two tables, which results in much congestion and discomfort.

Lack of clinic personnel.—Most of the clinics have only one or two doctors, and in many cases the same physicians are obliged to carry the work of the skin clinic in addition to that of the syphilis clinic. Two of the clinics have no social worker and only two have more than one. In most of the clinics the social worker's time is so taken up with clerical and routine procedures that very little can be done in effective follow-up work. It is easily seen that in a venereal disease clinic, individual attention and follow-up care are essential, and that clinics carrying from 500 to 1,000 patients cannot carry on this work with only one social worker. There is also a need for more trained laboratory technicians. Few of the clinics have such technicians as full-time workers, and this deficiency causes much delay in securing results of tests.

Lack of adequate hospital facilities.—This lack is especially felt in regard to the making of spinal punctures. All of the clinics depend upon beds in the general hospital wards for the purpose of spinal treatments, yet only four made any special provisions for accommodations of this

Adv. page 58

Sanitary Surfaces

With Johnson's Perfectone Undercoat and Enamel walls, ceiling, woodwork and equipment can be given a porcelain-like finish that will stand frequent washing with soap and water. Johnson's Enamel comes in satine white and soft tints which reflect light without objectionable glare. Color combinations that are cheery and restful may be obtained with this sanitary finish.

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Johnson's Perfectone Enamel is long in oil and gives an elastic, durable, non-porous finish. It will not fade, chip, check, crack or peel. Finish walls, trim and furniture with Johnson's Perfectone Undercoat and Johnson's Perfectone Enamel and you are sure of a perfect job because its smoothness and freedom from laps, brush marks and cracks, render it absolutely sanitary and germ-proof.

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Contains complete information concerning the proper method of finishing floors, walls, woodwork and furniture. Tells just what materials to use and how to apply them. Includes color card—gives covering capacities, etc.

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is in the hands of a corps of experts who give all questions on wood finishing prompt and careful attention. Do not hesitate to bring your interior finishing problems to us—there is no obligation whatever attached to this service.

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Please send me free and postpaid your book, "The Proper Treatment for Floors, Woodwork and Furniture."

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sort. There is also no provision, except in two of the large municipal hospitals, for the admission of patients to the hospitals for observation or for specialized treatment.

Clinic fees too high.—The charge for salvarsan treatment was found to range from $1.25 to $3 a dose. The charge for spinal puncture ranges from $2 to $4. These are almost prohibitive to the majority of patients whom the clinic handles.

Lack of free night clinics.—The study revealed only nine night clinics in the city, and of these, only the Department of Health clinic gives free treatment. Four others occasionally give free treatment to indigent patients. None of the night clinics make Wassermann tests. Thus it is impossible for a working man to secure these tests unless he can be excused from his work during the day.

Inefficient record system.—Few of the clinics use a special form for their venereal disease cases. Thus there is no detailed information about the social history of the patient and this phase is overlooked. Also, because of a confused filing system and lack of experienced clerical workers, records are sometimes lost or misplaced, so that social workers cannot secure data which would be important in their work.

Only two of the large municipal hospitals make provision for bed cases of venereal disease. These have fairly adequate accommodations for both gonorrheal and syphilitic patients, but they will not keep chronic third-stage cases of the latter more than a year.

In spite of the various deficiencies observed during this study, Mrs. Funkhouser notes an encouraging advance in results accomplished, even in the two-year period during which the study was made. Social workers are undoubtedly improving in knowledge of the medical and social factors involved. The growth in the number of venereal disease clinics and in their service to patients is something which should act as an incentive to continue work on this problem so that the situation may be entirely alleviated.

BUFFALO CLINIC IS ESSENTIAL TO COMMUNITY HEALTH, SURVEY SHOWS*

THE facts brought out by the social investigation of the Buffalo Urologic Clinic, which was made by the Buffalo Foundation at the request of the board of managers of the department of hospitals and dispensaries, indicate that the maintenance of a clinic for the diagnosis and treatment of venereal diseases is absolutely essential to preserve the public health of the community.

The venereal disease clinic of Buffalo occupies a series of rooms in the Health Center Dispensary Building at 51 Court Street. The personnel consists of a part-time physician-in-charge, five part-time assisting physicians, a head nurse and an assistant, an orderly and a clerk. The quarters are thoroughly sanitary.

Class of Patients Treated

During the period of thirty days in which the social investigation was being made, there were admitted to the clinic 165 new patients, 133 white and 32 colored. Of the 165, only 27 were females, but indications are that with further separation of the sexes the attendance of women will be markedly increased.

The ages ranged from 9 to 79 years. Children under 16 are sent to the children's clinic for regular treatment. The marital conditions of the patients is as follows: Of the 138 males, 34 were married; of the 27 females, 19 were married.

Of the 165, 108 were located either at or from their homes. The number of unlocated persons after one interview represented 19 per cent of the total. Most of these had deliberately given fictitious addresses in order to cover up their tracks. A regular social worker employed permanently in the clinic could trace these patients by asking to have them sent back to the interviewer in their next visit to the clinic.

As regards employment, only 42 of the 165 were known to be employed. Four were students, and for four others no information was available. Of the 115 who were not employed, 14 had been unemployed less than three months, 54 from three to six months, 15 from six months to a year, and six had been unemployed for longer periods, up to six years; 27 failed to give length of unemployment. The majority had been engaged in common laboring jobs, in factories, railroads, steel mills, etc.

The occupations can be classified into 37 different groups. The two largest are common laborers and factory workers. Some of the others were sailors, chauffeurs, garage workers, steel workers, domestic servants, motormen and even a clergyman.

Of the 42 who were employed, six were earning less than $10 a week, 17 were earning from $10 to $19 per week. Of the latter, five have from four to six dependents. Twelve patients earn between $20 and $29. Only five patients earn from $30 to $40. Most of the patients earning from $20 to $40 have dependents, which makes clinic treatment the only kind that they can have available within their budgets.

Conclusion of Sub-Committee

As a result of the investigation the Buffalo Foundation comes to the following conclusions:

The clinic managed under the municipality becomes a very important part of the educational program being carried on for the cure and prevention of venereal disease. Buffalo should enlarge the local program very much. There is need for much education through lantern slides, lectures, and films, by qualified persons. Industrial concerns should cooperate strongly in this.

The Buffalo department of hospitals and dispensaries deserves much credit for having entered this field early on the curative side and for having done a very creditable piece of work. Other agencies ought to do their share to develop the preventive and educational activities.

Much education is needed to instill into the minds of the public the knowledge that venereal disease must be treated as an infectious disease and cured as completely as possible, and that such conditions will never be attained until the public accepts the conditions as they are and agrees to do away with the traditional wall of mystery which has been established about the whole matter.

*Buffalo Foundation's Survey of the Urologic Clinic, Health Center Dispensary No. 5. From the report of Frances M. Hollingshead, M.D., director of Buffalo Foundation. Abstract Service, American Social Hygiene Association, February 15, 1922.

"Just What a Ligature Should Be"

Armour's Catgut Ligatures, Plain and Chromic, boilable, strong, absolutely sterile, 60-inch, 000 to 4 inclusive.

Iodized Catgut Ligatures, non-boilable, strong, sterile and very supple, 60-inch, 00 to 4 inclusive.

$30 per gross. Discounts on larger lots.

Also emergency lengths (20-in.) Plain and Chromic—$18 gross

ELIXIR OF ENZYMES
—aid to digestion and vehicle for iodids, bromides, etc.

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—astringent and hemostatic.

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—ampoules, surgical I c. c. obstetrical ½ c. c.
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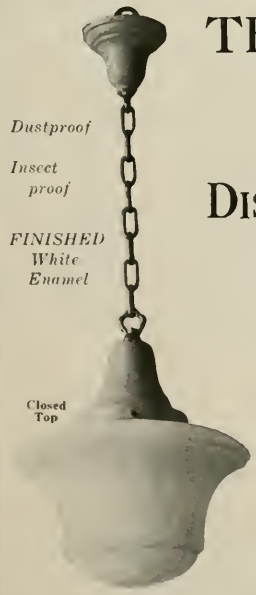

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A scientific mixture of three layers of Glass—Clear, Opal and Blue—the Blue layer filters out the annoying Red and Yellow Rays, thus eliminating all glare, consequent eye strain and fatigue.

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Discount to Hospitals

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Hints to Hospital Superintendents

OUTDOOR TREATMENT ON THE HOSPITAL ROOF

Are you treating your patients fairly in the matter of outdoors and sunshine? There are many diseases benefited by outdoor treatment and these possibilities are being further recognized every day. The foresighted superintendent will keep a step ahead of the times, and not allow his institution to be left behind in the onward march of medical procedure. By the full use of the hospital roof every institution may afford outdoor treatment, perhaps in a more efficient manner than if extensive lawns and gardens were provided. On the roof the patients may be sufficiently protected from the weather when necessary, and may be kept under closer supervision by the nurse in charge. You may say that your institution is so located that the roof would be smoky and disagreeable. Then you should work for a lessening of the smoke horror or a different location for the institution.

WASHING SOILED DRESSINGS

The following formula is used with success in the laundry of the Presbyterian Hospital of Chicago for the washing of soiled dressings:

Four cold rinses of two minutes each,
Three soda baths of ten minutes each,
Three hot rinses of two minutes each,
Bleach ten minutes and bring up to boiling point.
Three hot rinses and two cold of two minutes each.

After the dressings are received in the supply room from the laundry, they are separated, folded, wrapped and sterilized for three consecutive days.

THE TREATMENT OF RUBBER GLOVES

Nurses at the Royal Victoria Hospital at Montreal, Quebec, are given the following instructions in the notes of their supervisor, Miss B. K. Felter, O.R., for the care of rubber gloves:

"After rubber gloves have been used they are to be washed on both sides with cold running water, boiled in 1 per cent solution of sodium carbonate for five to twenty minutes. Then they must be dried, powdered on both sides, patched if necessary, mated properly, placed in a cotton cover and sterilized for twenty minutes at ten pounds of pressure."

TO MAKE SOFT SOAP

Many institutions find it economical to manufacture soft soap since it enables them to use up old grease and fat trimmings which would otherwise be pure waste. The following recipe for making soft soap is taken from the *Medico-Military Review.*

Old grease and fat trimmings, 12 pounds after rendering; concentrated lye, 4 cans. Water sufficient to make 50 gallons of soap. Dissolve the lye in 6 gallons of water; add the grease and allow the emulsion to stand for two hours; boil for 30 minutes with constant stirring. During the boiling, small quantities of water, about a quart, must be added from time to time to prevent the mixture from boiling over the top of the can. After boiling for 30 minutes, sufficient water is added to make up the 50 gallons of soap.

MARKING RUBBER GLOVES AGAIN

The method of marking surgeons' rubber gloves in use at Brandon General Hospital, Brandon, Manitoba, has proved most satisfactory, the superintendent, Miss S. Persis Johnson, declares. The initials of the surgeon are marked on the cuff of the gloves with a caustic pencil and they remain there without detriment to the gloves.

DRESSINGS FOR ONE OPERATION

Sterile dressings and supplies which the Royal Victoria Hospital at Montreal, Quebec requires for one operation include the following:

1 doz. towels.
3 doz. flat sponges with strings.
2 bags—small sponges.
3 dressings and bandages.
1 gown and pair of gloves for each surgeon and nurse; also caps and masks. Ether cones for face cases.
Roll dressing for arm or leg.
2 non-absorbent or kidney pads.
½ doz. abdominal towels.

THE FLY AND THE GARBAGE PAIL

Flies are perverse creatures. You may provide many traps for them and bait them temptingly, and a few will accept the invitation, but most of them will go to the garbage pail. If the trap is placed on the cover of the garbage pail every fly will be caught before he can make his escape.

LETTERS OF CLINICAL VALUE

Some hospitals make a practice in filing their correspondence to place all letters of clinical value to patients with the history. For example, letters from the patient's own physician, giving a knowledge of the case or letters bearing on the financial status of the patient are attached to his history and filed there.

"Cleanliness is the only real disinfectant. No epidemic can resist thorough cleanliness and fresh air."—Florence Nightingale.

Adv. page 62

The Ariston Line

STANDARDIZATION OF
FOOD SERVICE
IN HOSPITALS

IS Always Fine

COFFEE—The Universal Drink

"The Brown Berry of Arabia"

Coffee was first discovered by the Ethiopians and was carried to Abyssinia in 875 A. D.

The Greeks and Romans missed a good thing. They did not know about coffee.

In Constantinople in the 16th century, coffee was so popular that refusal to supply a wife with a specified quantity per day was a valid cause for divorce.

The first café (coffee house) was opened in Paris about 1675.

Early coffee houses in London were regarded with suspicion as gathering places for vicious and criminal characters.

Coffee grows in all tropical countries. Four-fifths of the coffee used in the United States comes from South America.

The coffee tree is the aristocrat of the tree family and must be handled very carefully. Each tree produces about five pounds per year.

Coffee planting in Brazil was begun about 1725. but cultivation on a large scale dates from about 1867. Brazil now produces seventy percent of the world's supply.

The greatest coffee railroad in the world runs from Santos to São Paulo over the Brazilian mountains and carries annually five million 130-pound bags of coffee.

In 1829 the U. S. import of coffee was less than 100,000 pounds; in 1921 it was about 25,500,000 pounds.

The difference in cost per cup between the best and the next best is so slight that there is real economy in having the best. Try our Golden Blend.

OUR GOODS and OUR SERVICE

We Import: Coffees and Teas. We Supply: Cocoas, Spices, Candies, Etc.
We Manufacture: Gelatine Desserts, Flavoring Extracts, Baking Powders
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Coffees are roasted on orders as received.
All goods sold are strictly guaranteed
All our goods are always pure and fresh
Prices are always reasonable and right
Packages of sizes convenient for institutions.

Sales are made direct, to institutions only
We give personal service on every order
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1892

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1922

LETTERS TO THE EDITOR

THE QUESTION OF PEDIATRIC NURSES

To the Editor of THE MODERN HOSPITAL:

The need of pediatric nurses is becoming a more serious problem every day. The medical world has at last been awakened to the fact that our next generation depends upon the proper care and teaching of the present.

Institutions can render no greater service to a community than to prevent diseases, and keep babies well; herein lies the solution of infant mortality. The greater mass of the public, the educated as well as the uneducated, fail to fully understand the value of health, their responsibility in attaining it, and their right to demand it. There is, in short, a very decided lack of interest in human health.

We rightly and willingly pay heavy taxes and expend vast sums for the education of our children, and yet what is education without health? There are thousands of children every year failing to develop intellectually because they are physically unfit.

We do find some very enlightened health officers, nurses, and doctors who are seeking to install better methods or procedures. But, as usual, they are met with the cry, "It costs too much." Notwithstanding, a great reduction has been made in the infant death rate. But the question before us is, "Are our institutions going to awaken to the fact that the infant mortality cannot be kept down if they do not produce the nursing staff to help the community?"

Our large and small training schools of today all have the most marvelous surgery and adult medical staffs and equipment. But go further, and nearly always we find the children's department drifting along as best it can. The trained nurse of today, on an average, knows no more of pediatrics on receiving her diploma than the average intelligent mother who has had the care of her children. Why? Simply because the training schools have neglected to give her the proper training in that course.

Most of our institutions of today have enough pediatrics to get the nurse over an examination of ten questions by the state examiners. Do you think that this is sufficient to qualify a trained nurse to care for sick children?

The hospital I am connected with trains infant nurses only, these nurses are given a thorough training in infant care, including surgery and infant feeding. But we would not recommend our nurses as qualified to meet all the demands of the profession.

The shortage of nurses for infant welfare work is becoming a serious matter, but as long as our training schools for nurses do not demand a higher standard in their pediatric departments we cannot expect to fill the gap. As a general rule we do hear the nurses expressing themselves as not liking to care for children, but I think this can be overcome by giving them a course in children's work in the same way that we do in surgery. They don't like pediatrics simply because they haven't had the proper training in that line.

If health protection is to be secured, the public conscience must be awakened to its importance, and the proper people must be trained to train others. We need faith in our cause and perfect organization to win in this fight, and if we have these fundamental qualifications the fight can be won.—Pediatric Nurse.

STEADY GROWTH IN A. H. A. MEMBERSHIP

The growth in the personal membership of the American Hospital Association can be readily traced from the following table published in a recent bulletin of the association. The two sharp drops in the total published roll were caused by the routine suspension of all members in arrears for dues. Many of these were later reinstated.

GROWTH OF MEMBERSHIP IN THE AMERICAN HOSPITAL ASSOCIATION.

Year—	Registered at Conference			Published Membership Roll							
				Personal					Institutional		
	Personal Members.	Voting Inst. Delegates.	Total.	Active.	Associate.	Life.	Hon.	Total.	Active.	Associate.	Total.
1899	9	...	9	...	...	...	...	...	...	...	...
1900	23	...	23	...	...	...	...	...	...	...	...
1901	44	...	44	...	...	...	...	...	...	...	...
1902	(?)	(*)	100	...	...	...	...	...	...	...	...
1903	45	...	45	...	...	...	...	...	...	...	...
1904	61	...	61	137	...	...	9	146	...	...	...
1905	77	...	77	201	...	...	10	211	...	...	...
1906	86	...	86	224	...	...	10	234	...	...	...
1907	132	...	132	273	...	...	13	286	...	...	...
1908	174	...	174	533	24	...	14	571	...	...	...
1909	204	...	204	531	51	...	14	596	...	...	...
1910	126	...	126	645	54	...	15	714	...	...	...
1911	286	...	286	788	40	...	15	843	...	...	...
1912	267	...	267	913	18	...	15	946	...	...	...
1913	376	...	376	996	20	...	15	1,031	...	...	...
1914	(?)	...	...	...	...	...	15	1,148	...	...	...
1915	(?)	...	...	...	...	...	15	918	...	...	...
1916	(?)	...	...	...	...	...	15	1,268	...	...	...
1917	(?)	...	...	...	...	...	15	1,241	...	...	...
1918	(?)	(*)	483	...	...	11	15	1,355	98	...	98
1919	216	190	406	...	...	11	15	1,060	285	...	285
1920	271	155	426	...	...	29	11	1,228	330	...	330
1921	328	156	484	...	...	31	11	1,386	409	...	409
1922	These Figures Will Be What You Make Them.										
Actual Membership. July 24, 1922				1,208	241	32	10	1,491	458	6	464

*With guests.

Ah, when shall all men's good
Be each man's rule, and universal peace
Lie like a shaft of light across the land,
And like a lane of beams athwart the sea,
Through all the circle of the golden year?"

Germs, says the U. S. Public Health Service, are usually a hand to mouth affair. Better wash up.

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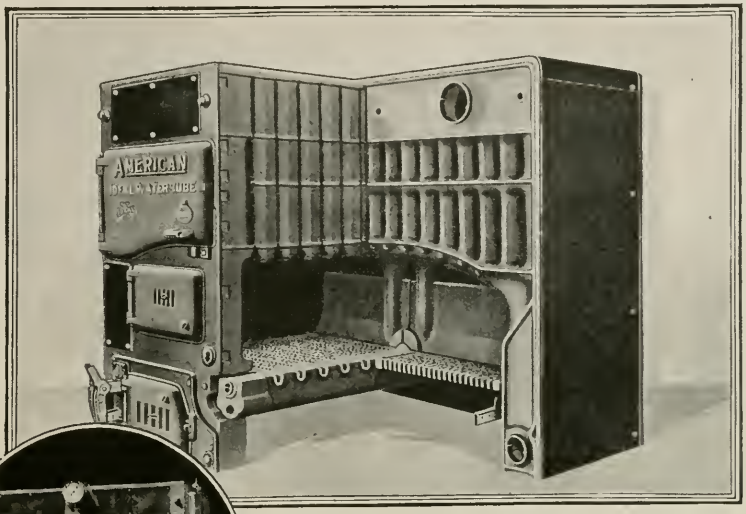

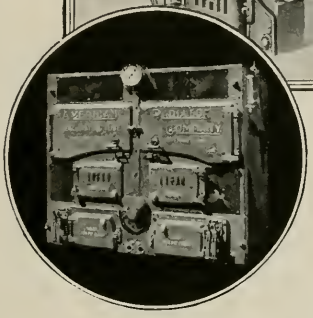

BUILT
like a bridge!

THE UNUSUAL DESIGN of the IDEAL 79-inch Water Tube Boiler is well shown in the cut-away view above.

Notice the bridge-like construction of the sections. No separate base is required; the weight of each section is self-supported by a substantial girder-like water-leg extending to the floor, which absorbs a large portion of the radiant heat below the grate and forms an air-tight, water cooled ash-pit.

The boiler is assembled in two separate halves, connected in the rear by single flow and return headers. Each half section has a cast-iron conical nipple connection at the top and bottom.

This unusual construction allows absolute *free* expansion and contraction, not only within each section, but of the entire boiler. All danger of strain at high firing periods is completely eliminated.

The wide, shallow fire box is made possible by the water-filled grate support in the center. This means easy and efficient firing. It also means easy shaking—for notice that the grates are in two sections, with two separate shaker-handles to each section.

Designed especially for hospitals, banks, theatres, hotels, churches and office buildings, the IDEAL 79-inch Water Tube Boiler, assembled either singly or in batteries, has practically unlimited capacity.

IF YOU are planning a hospital, or have one under construction, you will want the specifications and ratings of the IDEAL 79 inch Water Tube Boiler. Just send to either address below for our illustrated booklet containing full details.

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Book Reviews and Current Hospital Literature

A MANUAL OF OBSTETRICAL NURSING

Prepared for Use in Connection with Textbooks of Obstetrics. By Nancy E. Cadmus, R. N., General Director of the Maternity Center Association; Graduate of the Presbyterian Hospital School of Nursing of the City of New York; former Superintendent of the Manhattan Maternity and Dispensary; former Member of the New York State Board of Nurse Examiners; former President of the New York State League of Nursing Education.[1]

It is quite generally recognized that one of the most difficult problems in connection with the education of student nurses is to secure adequate instruction in obstetrical nursing, particularly if the parent school must send students to special maternity hospitals to get it. Equally difficult is the problem of managing a maternity hospital that depends on a constantly changing group of student nurses for the care of the patients and at the same time tries to give students a fair return in education for the work they do. In many obstetrical hospitals there is a change of students every two weeks. This does not mean that the entire group changes, but a certain number do. The result is that at any given time the students assembled for a given class may range all the way from the so-called "seniors" about ready to terminate their service, to the "juniors" who have just arrived. Added to this, any given class includes students who have come from a number of different hospitals, which invariably means differences in background and preparation.

From the teaching standpoint this represents an unusually difficult problem, and one that is so seldom met in any adequate fashion that where it is, it is considered an outstanding achievement, the fame of which is likely to spread abroad. It is an open secret that Nancy E. Cadmus, former superintendent of the Manhattan Maternity Hospital, was unusually successful in meeting this problem. So much so that for a period of years her work afforded an interesting demonstration of the fact that it was possible to meet the educational needs of the students, to provide adequate care for the patients, and to satisfy the claims of the hospitals sending students. It really was an unusual example of the possibility of satisfying what often seem to be antagonistic claims, and the mutual satisfaction engendered was no small part of the total result.

It is significant that Miss Cadmus has been willing to share the results of her efforts and experience with others. This Manual outlines the classes and demonstrations that are absolutely essential, stresses the correlation of theory and practice, even outlines quizzes. It is not intended to take the place of a textbook on obstetrical nursing, but rather to supplement such a text, and be used in connection with it. It is peculiarly valuable for the instructor as well as the student, both of whom are often bewildered because the textbooks contain so much, and the time devoted to instruction is so limited. With this Manual as a guide, the essential subject matter can be encompassed in even a limited number of lessons.

It is no small accomplishment to boil down essential facts, and state them in such simple English that they are brief and easily understood. This is the task Miss Cadmus set herself. Every page is an evidence of her success, perhaps no where better shown than in the section on "Maternity Nurse Visiting" and the "Advice for Mothers." Miss Cadmus has rendered a real service in giving this book to nurses.—C. E. G.

[1]G. P. Putnam's Sons. New York and London, The Knickerbocker Press, 1922.

MAN—THE ANIMAL

By M. W. Smallwood, Ph.D., Howard Professor of Comparative Anatomy, Syracuse University.[2]

"Man—The Animal," a brief book by Dr. W. M. Smallwood, professor of comparative anatomy in Syracuse University, is a popular summary embracing the most recent discoveries of modern biological science. The author frankly sets forth the limits which scientific investigation has reached at various points and presents the biological view of life, disease and death with remarkable lucidity. The general character of the book's contents may be gained from the titles of three or four of the chapters: Laws of the Living Protoplasm; The Biological Unit; What Makes Man Go; Heredity; The Laws of Sensation and the Nervous System of Man; Biology and Progress. It is a popular science of a sort that hospital superintendents, nurses and social workers have long desired and is worth careful perusal.

TEXT-BOOK OF THE PRINCIPLES AND PRACTICE OF NURSING

By Bertha Harmer, B.Sc. (Columbia University), R.N., Instructor of Theory and Associate Instructor of Practical Nursing, St. Luke's Hospital Training School for Nurses, New York; formerly Instructor of Theory and of Practical Nursing, and Supervisor of Nurses, The Toronto General Hospital Training School for Nurses, Toronto, Canada.[3]

This book challenges attention and well rewards serious study. It is quite unlike all former texts on nursing procedures, because it emphasizes and connects the underlying principles with the practical work in a way that is unique.

Now that this has been done one wonders why it has not been done before, for there has been a demand for

[2]The MacMillan Company, New York, 1922.
[3]The MacMillan Company, New York, 1922.

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The Johnson Pneumatic System of TemperatureRegulation contains within itself all the elements that go to make a good investment for hospitals. Its never failing, instant response to the delicate degree changes of heat and cold in each room affords an actual saving in the consumption of coal equal to much more than the interest on the cost of the entire installation.

JOHNSON SERVICE COMPANY, MILWAUKEE

just such a book for many years. The reason is not far to seek. To accomplish this task it was necessary to merge the over-emphasized loyalty due to any one school, or group of nurses, into the larger loyalty that stresses the fundamental needs of all schools and all nurses. This has been done so successfully that the book is refreshingly free from *isms*, and from overemphasis on the approved practices of any one school. The aim as stated in the preface is "to impress upon the student the fundamental principles of nursing, founded upon the ideals of service, its object being not only to help cure the sick and heal the wounded but to bring health and ease, rest and comfort to the suffering mind and body. Secondly, to emphasize the underlying principles of each practical procedure or technique."

It is quite evident that this clear-cut aim was constantly uppermost in the mind of the author, for every page bears evidence of it.

Two outstanding features of the book are the sequence and the completeness of the material presented. By sequence it is meant that the most elementary and most frequently used procedures are presented first, and there is a definite connection between one procedure and the next, as well as a steady advance from the simple to the more complex. In other words the principles of teaching have controlled the arrangement of the subject matter. This in itself is unique, because all too often nursing texts have shown how definitely the exigencies of work have controlled the teaching. The completeness is such that the book contains not only the fundamentals in nursing, i.e., the nursing care and treatments used in general medicine and surgery, but also the nursing care and treatments used in diseases of the eye, ear, nose and throat.

The illustrations are clear and helpful, as well as generous in number.

In an address made in 1917 by Miss Nutting may be found the following statement: "Just as improvements in the practical methods of nursing must be brought about by those who do the work, so the intellectual aspects of nursing can only be developed and presented by nurses who can see all that is involved of that nature in their own work." The author of this book has had the vision to see and the ability to present all that is involved in so-called practical nursing, and has thereby made it all the more practical.—C. E. G.

OBSTETRICAL NURSING

A Text-book on the Nursing Care of the Expectant Mother, the Woman in Labor, the Young Mother and Her Baby. By Carolyn Conant Van Blarcom, R.N., Formerly Assistant Superintendent and Instructor in Obstetrical Nursing and the Care of Infants and Children at the Johns Hopkins Hospital Training School for Nurses; Author of "The Midwife in England." With 200 illustrations and eight charts.[4]

This text-book is a welcome addition to the growing list of books written "by a nurse for nurses," and nurses may well be proud of this fact because it is an unusually good presentation of a subject, about which there has been no dearth of good books.

The author has had a wide and varied experience, which probably influenced her aim—to produce a book that would "be helpful to, and widen the outlook of all nurses, no matter where or by whom trained." Consequently the emphasis is on the underlying principles of obstetrical nursing. Not one method, but a "survey of nursing methods employed in maternity wards and hospitals of recognized excellence is presented." This is as it should be, for it is essential that student nurses should be taught not only the particular method in vogue in one school, but other equally good methods used elsewhere, for nurses must be able to analyze the advantages of different methods and choose the one most adequate for the satisfactory care of the mother and child in any environment in which they may be found.

The book is divided into seven parts, the first two of which deal with the normal anatomy and physiology of the female generative tract. Four of the succeeding parts are devoted respectively to a description of the nurse's duties during pregnancy, labor, the puerperium and early infancy. A separate part is devoted to a description of the organized care and instruction of maternity patients by public health nurses. Each part is unusually complete and well illustrated. In fact the illustrations, drawn as they are from so many sources, bear witness to the author's statement that she spent a year and a half studying the training given in maternity nursing in several hospitals in this country and Canada.

There are so many excellent features that it is difficult to select those worthy of special mention without making the list unduly long. But in even a casual examination one cannot fail to be impressed by the attitude which pervades every page, an attitude which is best expressed in the author's own words as an attempt "to give young nurses something of a feeling of reverence for the great mystery of birth" and "an appreciation of the significance of the event in which they are participants." It is no small achievement to have written a text that is preeminently scientific and practical, and yet dominated by such spirit. This in itself is enough to make Miss Van Blarcom's book an exceptionally satisfactory one to place in the hands of students, and justifies all nurses in being proud of her accomplishment.—C. E. G.

HANDBOOK OF ORGANIZATION AND METHOD IN HOSPITAL SOCIAL SERVICE

An Outline of Policies as practiced at the Johns Hopkins Hospital, Baltimore, Md. By Margaret S. Brogden, Chief of Social Service, the Johns Hopkins Hospital.[5]

Policies worked out in the social service department of Johns Hopkins Hospital in the thirteen years since that department was founded make up the contents of a handy volume by Miss Margaret S. Brogden, recently published under the title, "Handbook of Organization and Method in Hospital Social Service." The work is highly serviceable and it will undoubtedly become a standard reference book on social service practice.

In addition to a plan of organization and methods of procedure, outlined in the text matter, is a complete set of forms and records which with modifications might be adapted with benefit by many social service departments in hospitals, large and small. Miss Brogden, who is the chief of social service at Johns Hopkins with eighteen assistants, undertook the work singlehanded at its inception and her experience and conclusions cannot help but carry weight in the field of medical social service.

Almost every item that is of interest to the executive inaugurating such a department is treated of in the volume in a lucid and concise manner. The handbook should also be of value to teachers and students in schools of social work and to new workers, since it shows clearly the intimate relationship between hospital administration and department records.

[4] The New York MacMillan Company, 1922.

[5] The Norman, Remington Co., Baltimore, Md.

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. IV — *October 1922* — No. 10

PRESIDENT O'HANLON GIVES AIMS OF ASSOCIATION

PERMIT me to welcome you to the deliberations of the twenty-fourth annual session of this association, and again to thank you for the honor you conferred upon me when you made me your president, for I consider the election to the presidency of this association the highest honor that can come to any one in our work. Since my election my moods have varied, like those, I dare say, of every one of my predecessors. At first, like them I am sure, I determined I would take time by the forelock and prepare this message at once, but alas, like most good intentions, my resolutions came to naught and days and weeks and months flew by without a line, until at last when delay could no longer be permitted, I cast about for a subject, and it seems to me that everything conceivable has been written upon by my worthy predecessors.

Upon opening my mail one morning I received several questionnaires asking for information: What salaries are you paying your employes up to and including the superintendent? How has prohibition affected your hospital? What is the effect of the late war upon medical and surgical practice in the hospitals, on the profession and upon you as a superintendent? Should the superintendent of nurses be under the superintendent of the hospital? Can you recommend a certain sanitarium in New York advertising through the southwest a sure cure for obesity? Should osteopaths be allowed to practice in the hospital? Should hospitals be obliged to employ registered pharmacists? From Porto Rico came a letter asking about a cure for diabetes, and this and a variety of other letters, brought forcibly to my attention the fact that we, as hospital administrators, live in a mass of questions, and it occurred to me that I might pass a few of them on to you. So if the fragmentary remarks I shall make to you must have a title, I think it might well be "The Great Question."

As I said, we hospital administrators live in the midst of a mass of questions. They rise and confront us on every hand. They grow up like thistles in the field,—questions social, economic, financial, nursing, medical, industrial and international. We walk in a forest of them, some tall as trees and seemingly as big in girth, while others form a jungle of little irritating problems that catch at us and tear us as we try to make our way. Everybody seems so busy asking questions that nobody seems to have time to answer them. One favorite way of trying to answer them is to send out a questionnaire; as if we had moved forward toward the answer to one question by raising forty more. Never mind whether anyone answers or not; send out the question, then feel that you have done something. The sign of the times seems to be a huge question mark.

That the development and extension of the interests of this association have been along lines mapped out for it in an attempt to answer the questions of its members is perfectly apparent to one who looks over the program of its earlier conferences. In the beginning there were most valuable contributions to the literature of hospital administration by the recognized pioneers in the field. Then came the committees with their report on some particularly difficult or obscure question; then as a solution for the various perplexities appeared the question box and answer which now is seen in such large letters as a part of our program in the form of round table conferences. As time passed and our work broad-

*Presidential address of George D. O'Hanlon, M.D., superintendent, Bellevue and Allied Hospitals, New York, N. Y., read before the twenty-fourth annual convention of the American Hospital Association, Atlantic City, N. J., September 25, 1922.

ened, in order to meet the ever increasing demand for varied information it was necessary to set apart a place on the program for groups doing a special piece of work. These groups express themselves to you from the program, each year increasing in number in the form of sectior meetings.

Welcomes Section on Trustees

The seventh, the trustees' section, appears for the first time this year, and it would seem there could be no greater contribution to our association than will come from the closer relationship with the governing bodies of all of our institutions. Do your trustees annoy you? Should we educate the board of trustees? How much should the board of trustees know about the hospital? These are questions I have heard propounded from the floor at more than one of the previous meetings of this association, and I must confess it was more or less of a shock to find some apparent concurrence from members to the thought that trustees should be kept in ignorance regarding anything pertaining to the work for which they are responsible, and in the performance of which we are their representatives. In my opinion the best way to educate a trustee is to bring him and his hospital into the personal or institutional membership of this association, and in behalf of the association I today officially welcome this new section to our body.

The growth in our membership has been slow and steady, but not in any way commensurate with the number of hospitals springing up throughout the United States and Canada. In Bulletin No. 3 for this year, the executive secretary presents some interesting data relating thereto, with helpful interpretive suggestions which I commend to your careful consideration. Some of our more conservative members have expressed apprehension lest the increasing number of state, or independent, hospital associations would detract from our parent organization, and ultimately bring about its dissolution. While as conservative as any, I feel no such apprehension; on the contrary, I believe the field is broad enough, and we as executives should be sufficiently expansive in our views, to welcome any group, be it geographical, denominational or otherwise.

The facilities for communication as between members and officers of this association are, as you know, practically restricted to the bulletins issued at irregular intervals by our very able executive secretary. While individually and collectively we, as members of this association, are under limited obligations to the owners and publishers of the hospital journals now in the field, the time must come when we shall have a publication of our own. The American Medical Association has its journal; the American Psychiatric Association has its journal; the American Occupational Therapy Association publishes *The Archives of Occupational Therapy;* the Canadian National Association of Trained Nurses has its official organ in *The Canadian Nurse;* the American Nurses Association publishes *The American Journal of Nursing;* social service also has its journal, so why not the American Hospital Association?

Members Guide the Policy

The executive secretary will tell you the trustees are exercising a progressively increasing degree of control and supervision over the activities of the association. It is becoming more and more, as it should be, your association, and I think it is not too much to state very positively and definitely that the association is not controlled by any group or clique. The policy shall be whatever you would like it to be, but you must not sit quietly back in your office chair, keeping your ideas and suggestions to yourself. Send them to the trustees, or the secretary. I am sure nearly every one here today has some thought of his or her own of what should be done at this meeting. The number passing on to the president those suggestions I assure you is surprisingly few.

To meet the criticism so often openly expressed of the association's method of electing its officers, your trustees are this year offering a new and, we trust, more satisfactory form. While the committee will present for your consideration definite nominees for the respective offices, any member or voting delegate may place in nomination from the floor, any person he may wish, or he may place upon his ballot the name of any person he may prefer.

I often wonder how many of us pause to consider how much has really been accomplished by and through the hospitals in this country during the last fifty years. Do you realize the oldest training school in the United States has not yet celebrated its fiftieth anniversary, and that when it was established, there were only 140 hospitals in this country, including institutions for the insane, while today there are over 7,000—an increase of 5,000 per cent? That the first ambulance service in the world connected with a general hospital was established in the city of New York in 1869? That the first school connected with a hospital for the practical training of midwives was opened in 1911, and today twenty-eight states have laws regulating their practice, thus officially recognizing them as a professional group? That hospital social service dates back only seventeen years, and how many of us have

yet to be convinced that our staff is not complete unless we have one or more social service workers upon it? Are we all awake to the value of prescribed occupation, and are we giving our patients the benefit of this therapeutic measure, or are we just quietly resting back deluding ourselves that it is a fad or passing fancy?

Hospitals as Centers of Health Education

Our hospitals should be centers of social service, especially in the way of hygienic instruction. In the matter of prevention, hospital officials have a large and inviting field of labor. We should take a lively interest in the matter of public education, because, to my mind, that lies very near to preventive work. Disease, pauperism, crime, the alcohol question, as these relate to our own locality, all come within the purview of the hospital administrator, and he should prepare himself by study, not only of the patients coming to his hospital, but of their antecedents and surroundings, their work, their recreations and habits, in order that he may speak with authority.

The after-care or follow-up of discharged patients is happily being undertaken by hospitals through auxiliaries, special agents and trained social workers. This work should be widely extended. We should take a lesson from Timon of Athens, who taught that

> "Tis not enough to help the feeble up but to support him after."

The hospital so situated that it maintains an out-patient service will find here a rich mine for exploitation, and one which will aid materially in bringing cases promptly under care, but by the same token will reduce the pressure for beds within the hospital. If the hospital administrator can engage in teaching of any kind he should take advantage of it. Nothing sharpens ones wits so much as contact with a critical audience. The hospital that is doing its full duty is in itself a place of education—training the recent graduate in medicine in the application of medical science, training nurses, attendants, social workers, dietitians, technicians—a real laboratory for the study of psychology. The hospital superintendent who does not see opportunities for work beyond the restricted horizon of his hospital enclosure is shortsighted, and misses his opportunities for the best work, and the board of managers or directors which does not encourage him in making the best use of such opportunities, does not appreciate the full value possible to the community in the institution which it supervises, nor the opportunity for making the hospital do its full duty.

This is the day when efficiency in all departments of human endeavor is preached. The man, the machine or the hospital which is not working to its full efficiency is a losing proposition. It may be difficult sometimes to make those who hold the control, who govern the expenditures, see that some of the best returns from hospital activities can often be found in fields which at first glance do not appear worth cultivating or which may seem too remote. No better method could, in my opinion, be devised for awakening public interest in or public support and sympathy for the work we are doing, than by showing the public that the officials and personnel of our hospitals have not only an interest in the welfare of the patients in the wards, but also in that of the people of the community, in their health, in their work, in their environment, in their cares and perplexities, in their social problems, and herein lies much of the value of the Hospital Day or Week.

Must Avoid Complacency

The opening sentence of one superintendent to the trustees of his hospital in his annual report begins with this sentence: "The besetting weakness of a hospital superintendent is the complacency with which, when rendering the annual account of his stewardship, he reviews the operations of his particular institution." Is it not possible that too often complacency is shown not only at the time of making our annual reports but is a continuous condition of mind with many of us throughout the entire year? Are we sufficiently "alert with noble discontent?" Are we not too sufficiently satisfied if our patients are comfortably housed in wards not too crowded, the routine of the day's work not interrupted by untoward incidents, and our income commensurate with our expenditure? Are we content with keeping up with the procession or are we ambitious to lead the van? Do we indeed keep up with the procession when we compare our work and results with what is being done in other general hospitals over the land?

"Faithful are the wounds of a friend"; remember please, should there be any querulous ones, my queries are not in the line of criticism. I do not place myself in the category of those who know a little more than you, but, on the contrary, much less than many. Neither do I propose to deny what I cannot see, nor deride that I have never felt. For more years than I care to remember I have watched the progress of general hospital administration, and have longed for the time when as a field of work for ambitious men and women it should come into its own. I believe the time is coming; it remains for us to hasten or hinder the day.

ASA S. BACON'S ADDRESS OF ACCEPTANCE OF THE OFFICE OF PRESIDENT

I CAN hardly express in words my appreciation of the honor you have bestowed upon me, but I can honestly say that if I have made any success as a hospital superintendent, it is due principally to my many years of activity as a member of the American Hospital Association.

When I first took up hospital work, nearly twenty-five years ago, I realized that to succeed, hospital workers must in some way get together for the exchange of ideas; therefore, as soon as I had the opportunity, I joined the American Hospital Association. I was not alone in this thought, for if you will notice our membership list from the beginning, you will see that it is composed of hospital workers whose institutions are the most progressive in the country. In order to do the greatest amount of good to the sick of our land, every hospital, no matter how large or how small, should become a member of our association for moral support and for our mutual benefit. Our association is not in business to make money. It is run on the same basis as our hospitals. The officers and directors give their time and labor without any remuneration. To the various committees we owe our gratitude for their services given free of charge, the only salaried officer being your executive secretary.

Asa S. Bacon, the new president.

We need your membership in order to carry on the program for the future. Where there is no growth and development, there is disintegration; therefore we must speed up our development.

I believe that every factor pertaining to hospitals should be studied and adjusted as rapidly as possible, and permanent bureaus established for all departments that are necessarily continuous. This should be done as quickly and as conservatively as conditions will permit.

We have created conditions in and around our association that make it compulsory for us to forge ahead in the interest of our hospitals.

From now on, we should be a fast-moving organization, always alert, taking advantage of every change in our laws, in hospital administration, in our medical and nursing schools, and instantly passing it on to our membership. Our guiding star is "higher standards in the care of the sick," to attain which we must be at all times a constructive organization.

I believe that if we can group all our interests into state organizations, which are under the direction of the parent organization, we can become the greatest factor in our government for the promotion of health to our people throughout the land. We can accomplish this when we hold in our files a complete membership of the hospitals of the two countries, thus working together as a unit for proper laws and standards in the care of the sick.

The American Hospital Association now seems destined to be a potent factor in the development of progressive and efficient hospital service to the public; therefore the management of the association now exercised by its trustees and officers becomes a most sacred trust.

As a great building reflects the ideals of its designers and builders, so our association represents the ideal of those who conduct its affairs; therefore your officers will continue to give serious thought to the future policies of our association.

"To some extent we barter our health for the other valuables—knowledge, skill and habits of utility to the community. At present we probably sell too much of health, but it would be equally unwise to sacrifice everything for health. It is better to be a Socrates with a headache than a perfectly healthy pig. There must be a compromise."—Thorndike.

FEEDING 2,000 IN THE CONGREGATE DINING ROOMS OF BOSTON STATE HOSPITAL

By ALBERT S. KENDALL, of Kendall & Taylor Co., Architects, Boston, Mass.

BOSTON State Hospital is an institution for the care of the insane, owned and supported by the commonwealth of Massachusetts. It cares for about 2,000 patients in two groups of buildings. These groups, called respectively the East Group for women and the West Group for men, are separated by about a quarter mile of open fields bisected by Morton street, one of the city's main highways to the southward. This separation into two groups is the result of a union of two city-owned institutions which were taken over and combined by the commonwealth some twelve years ago. It explains the necessity for the two congregate dining rooms illustrated herewith.

Another question will immediately suggest itself to anyone glancing over the plans: Why build the two dining rooms on different plans? The answer is—topography. The West Group dining room, which is for its site and surroundings ideal, could not be built upon the only available site at the East Group and secure that convenience for patients, central location and proximity to supplies which was considered vital to its success. On the site chosen there is a steep bank which brings the kitchen a full story below the level of the buildings from which the patients approach the dining room. It is desirable to have the kitchen on the ground floor for easy access for food, coal and the removal of garbage and ashes. The patients on the other hand should not have to go up or down stairs more than can be avoided to reach their dining room. Thus the two-story dining room was decided upon in spite of the difficulty in carrying prepared food up one story.

Built After Long Study

In studying the problem of adequately feeding 2,000 patients and employes the superintendent, Dr. James V. May, and the steward, Arthur E. Gilman, with the architect visited a number of institutions and made a prolonged study of plans and methods of service. Obviously the method of serving patients would in large measure determine the essential features of the plans.

The extremely interesting methods adopted by Dr. Harrington at Howard in Rhode Island gave valuable hints and were adopted with certain modifications. The West Group plan was inspired by a similar congregate dining room at Central Islip on Long Island, and we are indebted to Dr. G. A. Smith of that institution for some valuable hints.

The plans of the West Group are designed to be enlarged if needed by the addition of another group of three dining rooms at the other side of the kitchen building.

The plan at present consists of the kitchen, with scullery, storage, and refrigerating machine in the basement, three dining rooms each seating 200 patients, a central patients' serving room, a separate serving room for employes, a dining room for orderlies and attendants, and another for women nurses. Seven hundred and fifty persons are served in the dining rooms and 600 additional patients are served in the buildings to which they are confined. The disturbed patients and the infirm do not come to the dining rooms.

At the East Group 500 patients and 150 nurses are served in the building and about 200 patients are served outside the dining rooms.

Method of Food Service

The method of service is simple and effective. It succeeds in getting the food to the patients promptly and in a palatable condition. It arrives hot on the plate and with remarkably little fuss and confusion. The menus are of course simple, consisting of comparatively few dishes which greatly simplifies matters. The food is taken from the steamers, or kettles from the range, as the case may be, and transferred to covered containers on a wheel cart. The loaded cart is run into the central serving room where, if necessary, the food can be kept hot by placing it on the hot tops of the steam tables. The top surface of these tables is flat and without any wells or pans. It is seldom, however, that it is necessary to reheat any food, since covered containers have proved quite capable of retaining sufficient heat.

In the serving room the heated dishes are taken from the lower part of the steam tables or from the dish warmers and the cart continues its way to the far end of the living room. The patients meanwhile have come in, leaving their coats and hats in the coat room and taken their seats at the long tables, twelve patients at each table, six on each side. The food container and sufficient warm plates are removed and placed on the end of each table, the carriage returning to the serving room. The attendant serves the food from the container to the dishes which are passed down the

line by the two patients who sit in the seats next the ends. Each container of course holds just sufficient food for twelve patients. Second helpings when given are served from additional containers, kept warm in the serving room. Desserts are served in the same way after the empty containers have been collected. It is possible to serve a full dining room of 200 patients in five minutes in this manner.

At the East Group there are 500 patients in each dining room, but the same method is followed out. The containers are larger, for there are more patients at each table.

The dining rooms are very simple in construction and decoration, but they are high and airy and easy to clean. They can be and are flushed with a hose when necessary. Floors are fireproof, of concrete with terrazzo surface and wall base six inches high. The toilet rooms have a terrazzo dado six feet high. Walls are of brick plastered and the ceiling is plastered with the wooden roof trusses showing. The type of furnishings are shown in the pictures. The little entrance porches are about the only architectural touch in an otherwise rather severely utilitarian building.

The serving room, located at the junction of the three dining rooms is similar to the dining rooms in furnish. It contains the three plain top steam tables, three warming ovens, dressers for dishes and cutlery, three sinks and the coffee urns. The urns are of aluminum, are steam heated and are provided with a spray ring. The capacity is sixty gallons each. There is ample room for circulation and for the maneuvering of the three rather large food carriages, which move of course in three distinct lines of traffic.

Adjacent to the serving room and forming a part of the corridor connecting with the kitchen is the dish washing room where all the patients' dishes and silver are washed. The washer will cleanse and sterilize, if necessary, 6,000 dishes per hour, and the dishes coming out hot will dry themselves. Ample table space has been provided, as the dishes go through the washer faster than they can be returned to the tables or dish warmers by the help available.

Kitchen Floors of Red Tile

The kitchen floor is of heavy red quarry tile about 9 inches square and three quarters inch thick. This tile is laid with block joints about one-half inch wide. It is not possible to lay this sort of tile with a close joint and have it appear well, as the tile varies considerably in size. It is, in the opinion of the writers, however, the best floor for a large kitchen; cement floors deteriorate rapidly under the kettles and the lighter tiles will not stand the heavy traffic. Slate or bluestone is good but fails to equal the red tile in appearance.

The dado is five feet high and made of polished terrazzo. White Portland cement is used in the terrazzo which gives a cleaner appearance than the grey cement and takes a much higher polish. The floor is provided with several floor drains and can be cleaned with the hose with ease, as is quite evident in the picture. It was taken just after the floor had received a thorough hosing and the water is seen standing on the floor before it was mopped.

Hoods Not Used in Kitchen

One familiar with institution kitchens will notice the absence of any overhead piping or hoods. The smoke pipes from the ranges and broilers are taken down through the floor and thence to the flue directly back of the range. The vapor pipes from steamers, kettles and roasters are likewise taken down through the floor, carried along under the floor and up to the top of the chimneys. These pipes are six inches in diameter. The kitchen is high, twenty feet to the monitor, which can be opened or closed from the floor at will. There has never been any excess of steam in the room, or any condensation on the ceiling. Care is used not to allow live steam to escape into the room, and the hood has not yet been missed. Indeed its absence is greatly appreciated.

The advisability of leaving out the hood was considered at some length, and disaster was fully prophesied. When the fixtures were finally in place and connected, they were filled with water and steam turned on at every fixture. The vapor pipes easily handled all the steam. The only steam escaping into the room was when the covers were opened, and this, together with a blowoff from a safety valve on one kettle, did not cause enough to be disagreeable or to form any condensation on the ceiling. The essential points are large vapor pipe area, height of the kitchen and direct venting to open air at the top. Really much of the escape of steam in kitchens is due to carelessness in handling the fixtures.

All the kettles and roasters are aluminum and have connections for water, steam, return and drainage.

The drainage, except the toilet rooms, is connected through a cast iron grease extractor which contributes regularly to the income account by saving a considerable amount of valuable grease. The grease is drawn off regularly into a barrel without the necessity of skimming the grease trap, a distinctly disagreeable task.

The side door in the kitchen is the delivery point for food which goes to the buildings for the disturbed or infirmary patients who cannot come to the dining rooms.

500 PATIENTS AND 150 NURSES ARE SERVED IN THE EAST GROUP

In the center is a view of the East Group kitchen wing from the rear. Above are two interiors of the kitchen; below are the scullery and pan room (left) and the second floor serving room for patients.

THE WEST GROUP OF BUILDINGS WHERE 750 MEN PATIENTS ARE FED

The exterior view shows the West Group kitchen wing on the right and the entrance to one of the patients' dining rooms on the left. Above are a patients' serving room and a patients' dining room. The main serving room and the kitchen are shown below.

At the rear of the kitchen is a pan room where the kitchen utensils and the food containers are cleaned and stacked when not in use. The elevator, a plunger type, opens at the rear of this room. This elevator is used to bring coal to the range, to transport prepared food from the scullery below and to remove ashes from the basement where they fall from the range gates.

On the other side is the cook's room and behind that the cook's refrigerators. The stairs, bread room and a large milk refrigerator complete the equipment of this building except for the basement.

There is no finished cellar under the dining rooms; simply space for piping and room to get at it.

The cellar under the kitchen is used for scullery and storage. Coal is stored in a pocket outside opening into the scullery. Ashes are dumped into a brick chamber directly from the range fires and removed at intervals. The dirty work of the kitchen is thus all confined to the basement, making it easy to keep the kitchen always clean and neat.

There is a five-ton automatic ammonia refrigerating plant in a room under the cook's room and cold boxes. The refrigeration is by direct expansion of ammonia gas with automatic control of temperatures. The boxes are constructed of four inch solid cork block erected as self sustaining partitions, and plastered on the inside with Portland cement and sand, and painted with enamel.

The floors are of terrazzo with terrazzo bases. The floors drain to the doors so that when hosed down the water runs to the floor drain in the cook's room.

Garbage is placed in underground garbage containers located in the platform at the rear of the kitchen and is removed to the piggery every day. The underside of the garbage containers is accessible through doors in the front wall of the platform, so that a hose stream can be turned in when necessary to clean out the garbage that through carelessness is inevitably spilled over the flanges.

The East Group kitchen is similar in arrangement to the West, and the general points of service are the same. This kitchen is located quite close to the storehouse and bakery, which serves the whole institution, so it differs in minor particulars. Refrigeration, for instance, is obtained by an extension of the brine circulation system which cools the general cold storage and ice plant location near by.

At the East Group the patients eat on the upper floor and their food is brought to them by means of two lifts from the first floor serving room. The ground floor dining rooms are used by nurses and on the other side by a number of male patients who are employed on the east side in the laundry, boiler house, bakery and about the grounds. These men also have a lounge and smoking room in connection with their dining room.

The two-story arrangement necessitates a duplication of the dish washing machines, and introduces other complications which prevent the plant from being quite as ideal as the West Group. The kitchen itself, however, is much the same and is run on the same plan as the other.

Fixtures for Kitchen

The following list of kitchen fixtures is complete for the West Group kitchen. The fixtures shown in the pictures do not quite tally with the list, as the installation is not yet complete in all details:

Kitchen—
- 12 ft. double face range, 6 fires, 6 covers.
- 36" coal broiler.
- double steel bake oven, each 48x34x76.
- 4 aluminum kettles 80 gal.
- 4 aluminum kettles 60 gal.
- 6 aluminum roasters 80 gal.
- 4 vegetable steamers, 3 compartment.
- 2 steel cooks tables 10′ x 3′ x 33" with sink.
- 2 sauce pan racks 10 feet long.
- 2 10′ x 3′ x 33" plain steel tables.
- 2 coffee urns 40 gal. aluminum.
- 1 mixing machine with all attachments.
- 1 meat slicer.
- 1 steam table, flat top 10′ x 3′.

Pan room—
- 2 pan sinks, metal with drainboards.
- racks for containers.

Scullery—
- 2 vegetable sinks, metal 3 x 3" x 20".
- 2 wooden tables 10′ x 3′.
- 1 vegetable peeler.
- 1 twin ice cream freezer with ice breaker.

Cook's room—
- 1 steel table 8′ x 3′ x 33" with sinks.
- 1 dresser

Bread room—
- Bread racks, metal.
- Power bread slicer.

Serving room for patients—
- 3 steam tables 12′ x 3′ x 33".
- 3 dish warmers 5′ x 2′ x 6′.
- 3 dressers.
- 2 coffee urns 60 gals. each.
- dish washer and tables.
- 3 sinks.

Serving room for nurses—
- 1 sink.

Steam table containing—
- 2 platters 14".
- 2 gravy wells.
- 4 vegetable dishes.
- 4 jars 10½".
- 2 coffee urns 30 gallons.
- 1 dish washer and tables.

ISSUES DIRECTORY OF SANATORIUMS

A directory of Canadian agencies for the diagnosis and treatment of tuberculosis has recently been compiled by the Canadian Association for the Prevention of Tuberculosis. It shows that there are in the provinces of Canada 4,057 beds available for tuberculous patients.

DIMENSIONS OF PRIVATE ROOMS

By HENRY C. WRIGHT, Hospital Consultant, New York, N. Y.

THE dimensions of private rooms are of great variety, not only as to relative square foot area but also as to the relation of their long to their short axis.

This paper is a brief study to determine if possible the minimum space requirements, and under what conditions it is advisable to exceed this minimum.

There are rooms in many different hospitals that have been in successful operation for many years whose dimensions do not exceed 8x11 feet, with the long axis at right angles to the corridor. In rooms of this size and orientation there can be but one window and the bed must be placed parallel and adjacent to the side wall.

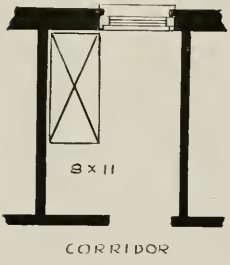


Fig. 1

A patient in a bed pushed against the side wall must be served from one side of the bed or during service the bed must be pulled into the middle of the room, a thing difficult to do in a room but eight feet wide, owing to the interference of furniture. Moreover, a patient placed at right angles to the outer wall must so lie that either he cannot look out of the window or, if his head be reversed, he must face the window and cannot avoid its glaring light. There are rooms in successful operation in the Presbyterian Hospital, New York, of the dimensions given in the illustration, with the bed crosswise of the room.

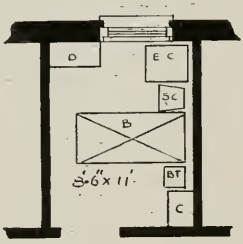


Fig. 2

D—Dresser and clothes press.
EC—Easy chair.
SC—Straight chair.
B—Bed.
BT—Bedside table.
C—Commode.

The square foot area of this second room is 93.5 but a little greater than the 8x11-foot room. It is a much more serviceable room from every standpoint. Though not wide enough to permit free passage at the foot of the bed, particularly for a wheel chair, nevertheless it is a reasonably serviceable room from the standpoint of the patient, the nurses and the doctors.

The two rooms illustrated above of nearly the same dimensions are each serviceable, one somewhat more so than the other. If ten square feet were to be added to either of these rooms, in which dimension would it be most advantageous? Let us assume that the general consensus of opinion is that a bed standing parallel with the corridor is the most desirable, will a room that permits of so placing the bed, namely one 8½x11 feet, gain more by adding 10 square feet to its width or to its length? This will be determined chiefly by two factors, the placing of the furniture and the services about the bed. The placing of the furniture is also illustrated as in Fig. 2.

The furniture, as indicated, consists of a bedside table, a straight chair, an easy chair, a dresser and clothes press combined and a commode. There is free space about the side of the bed. It would be advisable to have a bedside table on either side of the bed. This would require greater length in the room, but the cramped space at the foot of the bed probably hinders service much more than the lack of an additional bedside table. Greater ease of service is of more importance than furniture in addition to that indicated. Thus if the room were to be made 9½x11 feet it would be found more serviceable than were it made 8½x12½ feet. A room 9½ feet in width allows three-foot free space at the foot of the bed if the head of the bed is shoved tight against the wall; if, however, it is pulled away a few inches, as it should be, the space at the foot will be about 2½ feet. This is just sufficient space to permit two persons to pass and sufficient through which to roll a wheel chair. A three-foot free space at the foot of the bed is necessary for easy work about the bed. Thus a room should be made 10 feet in width before it is lengthened beyond 11 feet on its long axis.

Which Dimension to Increase

Assuming that in our calculation we have arrived at a room 10x11 feet, with its long axis at right angles to the corridor, and that the finances of the proposed hospital are such that a somewhat larger room can be provided, to which dimension shall the extra space be added?

The size of the room will be gauged primarily by two factors: first, the service that is to be rendered to the patient; second, the comfort and general well being of the patient. How big a free floor space is needed for service to the patient? These services may be listed as follows

so far as they relate themselves to floor space: (1) Bringing a wheel stretcher into the room and running it alongside the bed; (2) Turning the bed about with the purpose of taking it out of the room; (3) A service to the patient which requires two persons, one on either side of the bed; (4) An examination of the patient by an attending physician with possibly two assistants.

A space of three feet at the foot of the bed, three feet clear on the side of the bed toward the window and four feet clear on the side toward the door will permit all of the foregoing services to be carried on with comparative ease. Two feet must be allowed for furniture against the outer end of the room. Other necessary furniture can be placed against the wall toward which the bed heads. With a 3-foot 6-inch bed the lengthwise space required would be 2+3+3½+4=12½ feet with a width of ½+6½+3=10 feet. If this area 10x12½ feet be clear of a closet or a lavatory it is a space sufficiently large in which to minister easily to the patient.

Now as to the comfort and general welfare of the patient. This is a factor hard to measure. A person accustomed to a small bedroom at home will be content with a small one in a hospital. On the other hand a person who has had a large bedroom in which to move about will feel somewhat cramped in a hospital room 10x12½ feet. Moreover a patient who has had the privilege of a large bedroom will feel more at home if a little furniture in addition to the bare necessities be in his hospital room. What additional space should be added for this factor of the patient's comfort and to which dimensions should it be added?

Increasing a room in width by one foot, from 10 to 11 feet, does not provide space for additional furniture but does push the opposing wall somewhat further away from the patient and gives him a sense of space. If the width be increased to 12 feet furniture can be placed along both side walls. It requires less floor area to lengthen the room by one foot than to widen it by the same amount. Thus it will be more economical to extend the length from 12½ to 13½ feet or to 14 feet than to widen the room from 10 to 11 feet. Lengthening the room provides space for the additional furniture. But all the furniture any patient or his friends should be able to use, except a couch, can be placed readily in a room 10x13 feet.

Some Typical Up-to-Date Rooms

If funds are ample a room larger than 10x13 feet is advisable from the standpoint of the general welfare of the patient. The following are the room sizes in a few well known hospitals having comparatively recently constructed buildings:

Henry Ford, Detroit, Mich.	9'10"x16'
Mt. Sinai, Cleveland, Ohio.	10'x14'
Robert Packer, Sayre, Pa.	11'-1"x12'-6"
Elizabeth Steel Magee, Pittsburgh, Pa.	10'-8"x14'
Carson Peck, Brooklyn, N. Y.	11'x13'-9"
Brooklyn Hospital, Brooklyn, N. Y.	13'x13'
Massachusetts General Hospital, Boston.	11'-3"x19'-2"
Mount Sinai, New York, N. Y.	11'x15' and 16'
Royal Victoria Ross Pavilion, Montreal, Quebec	13'x16'
James Buchanan Brady, Johns Hopkins, Baltimore, Md.	10'-1"x16'

It will be noted that the width of these rooms ranges from 9 feet 10 inches to 13 feet and the length from 12 feet 6 inches to 19 feet.

The Henry Ford Hospital received a large amount of study particularly from the standpoint of producing the most serviceable yet economical room unit. It adopted a room width of 9 feet 10 inches but put an unusual amount of space in the length of the room, viz. 16 feet. This is clear space without deductions for closets, lavatories, etc. Moreover, in the Ford Hospital the bed, which is parallel to the corridor, is about five feet from the rear of the room giving a large amount of space between the bed and the window. This is the reverse of the usual custom of placing beds. More frequently the bed is so placed that the larger portion of free space is between the bed and the inner end of the room. This places the working space where it can be reached by the fewest steps from the corridor. Owing to the location of the bathroom door (each room has a private bath), which is at the head of the bed in the Ford rooms, the free space beyond the bed becomes largely the working space.

The working space in the rooms of the private pavilion of the Massachusetts General Hospital is at the inner end of the room. The rooms are 19 feet long, and the bed is about 4 feet to 6 feet from the outer end, leaving a clear space of 10 feet to 12 feet between the inner wall and the bed. The bathroom door, however, is entered from the inner space; thus it is not necessary to pass the bed to reach it as in the Ford rooms. If a hospital has funds sufficient and wishes to build very large rooms like those in the Massachusetts General it would be well also to follow this scheme of locating the bed.

Judging by the experience of hospitals generally there is little occasion to make a room wider than 11 feet or longer than 16 feet.

The foregoing comments have been made on the type of room most generally used. It seldom has more than one window. In some of the old hospitals rooms were made with the long axis paral-

lel with the corridor. Present day practice with very few exceptions runs the long axis at right angles with the corridor. Thus the narrow dimension abutting the outer wall permits but one window.

In the Presbyterian Hospital, New York, a hospital plant which is soon to be abandoned because it is inadequate, are a few rooms with the long dimensions parallel with the corridor and with two windows. These are the most cheerful rooms in the hospital. They are flooded with light, and the nurses feel these rooms are the best in the hospital from the standpoint of ease of service and work. A room of 12 feet, with its long axis parallel with the corridor, can have two good-sized windows. It has more free, utilizable floor space than a much larger room with its long axis at right angles to the corridor. There is no question that a room with two windows provides very much better ventilation than can be secured with one. With two windows one can always be left open without a draught on the patient.

A room of this type accommodates furniture better than the usual type of room. Roosevelt Hospital, New York, has many rooms 11x13 feet with the long axis parallel with the corridor. In these rooms are the following pieces of furniture: bed, dressing table, three straight chairs, one easy chair, couch, commode, clothes press, screen, invalid table. A hospital room seldom has so much furniture. This room though only 11x13 feet contains not only the foregoing pieces but in addition has abundance of free space for service. A room of these dimensions with the long axis at right angles to the corridor could not accommodate so many pieces of furniture and have remaining ample service space.

The private pavilion of the New York Hospital was built about twenty years ago. Most of its rooms are 12 feet parallel with the corridor and 14 feet in depth. Each of these rooms has two windows. The 12-foot dimension is ample and the 14-foot depth is in excess of need, especially if a toilet and closet are provided adjoining the room. Under these conditions a room 11 feet in depth would be sufficient. A room 12x12 feet would appear to be generous in proportions and would permit the two windows which are highly desirable.

A hospital with rooms arranged as above indicated would cost slightly more than one with rooms having the long axis at right angles to the corridor, since this arrangement would require some additional outer wall. The hospital would be longer and narrower, a form not well adapted to congested city blocks. But where ground space is ample a little extra expenditure will greatly improve a hospital by providing rooms with the long axis parallel with the corridor and with two windows. This type may be illustrated by the following diagram:

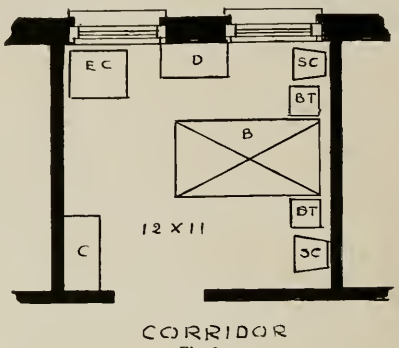


Fig. 3

EC—Easy chair.
D—Dresser.
ST—Straight chair.
BT—Bedside table.
C—Commode and clothes press.
B—Bed.

If a toilet or bathroom and closet be provided for the room, the commode-clothes press would not be needed, resulting in additional free floor space.

RESERVE OFFICERS PLAN TO ORGANIZE NATIONAL MEDICAL SECTION

Permanent organization of a Medical Section of a National Reserve Officers Association will probably be effected this month at the national convention of the American Legion in New Orleans, it is announced.

During a recent encampment of the medical, dental, veterinary and medical administrative officers of the U. S. Medical Department Reserve Corps, 4th Corps Area, at Camp McClellan, Alabama, a temporary medical section was organized. Lieut. Col. Hardie R. Hays of Jackson, Miss. was named acting president and Maj. L. H. Webb, M.O.R.C., of New Orleans, acting secretary.

The following resolutions were passed by this organization:

"We, the medical, dental, veterinary, medical administrative officers of the Medical Department Reserve Corps, U. S. Army, of the Fourth Corps Area on active duty at Camp McClellan, Alabama, July 12 to 26, 1922, for the purpose of field training, being in meeting assembled and desiring to express our appreciation for the training and courtesy shown, be it resolved:

"1st—That we tender to Surgeon General and subordinates, to the Commandant Organized Reserve Corps, Camp McClellan, and subordinates, particularly Camp Surgeon and his staff of trained instructors, our sincere appreciation and thanks for the competent manner in which the technical instruction was given and courtesies shown.

"2nd—That we go on record as endorsing this plan of training for medical officers and hope that steps will be taken to procure the necessary funds to extend training in the future to a larger number.

"3rd—That we are unanimously opposed to the initial appointment of officers in the Medical Reserve Corps above the grade of first lieutenant, who were not on active duty during the World War.

"4th—That we further oppose any policy that places restrictions such as age, etc., or attendance at camp and any other restrictions of medical officers' promotions which are not placed on promotions of reserve officers in the line. Attention is respectfully invited to the fact that medical officers are in civilian life practicing every day their branches, and those officers of the non-technical branches are not practicing the form of duty upon which they will be called to function in time of war.

"5th—That copies of these resolutions be submitted to the Surgeon General (through Camp Surgeon) and Camp Commandant, Camp McClellan, Alabama, also that copy be furnished the Journal of the American Medical Surgeons, THE MODERN HOSPITAL, American Pharmaceutical Journal, National Dental Journal, Military Dental Journal and American Veterinary Journal.

"Committee:
L. H. WEBB, Major, M.O.R.C., Secretary, New Orleans, La.
F. M. HARBIN, Major, M.O.R.C., Columbia, S. C.
F. M. BOYETTE, Captain, M.O.R.C., Oneida, Tenn.
L. H. BREVARD, 1st Lt., M.O.R.C., Hernando, Miss.

THE REAL SIGNIFICANCE OF THE DISPENSARY IN HOSPITAL PRACTICE

By SAMUEL W. LAMBERT, M.D., Chief Attending Physician, St. Luke's Hospital, New York.

IN CONSIDERING the development of a hospital service the controlling radical principle to be recognized and carried out in all its details is the fact that the whole hospital in all its medical functions is a single institution for the treatment of the sick and injured. The modern hospital reflects the growth of medical science during the past fifty years and as each new and epoch-making discovery has been announced, the hospital has been compelled to add a new department to its growing activities. Any hospital could be considered in the first rank, in the seventies and eighties of the nineteenth century, which conducted a dispensary, the ward service and a laboratory of pathology, while its minimum amount of chemistry and clinical microscopy was done at a table in the laboratory.

The complete institution today also must have at least a laboratory for bacteriology and serology, another for chemistry and another for radiography, to say nothing of the new methods of investigating cardiac diseases. In addition, the extension of the rational care of the sick has introduced the great advances in philanthropy which are grouped together under the auxiliary work known as social service. These newer additions to an up-to-date hospital have increased not only the power to diagnosticate disease, but also the facilities for treatment and extensive plants for hydrotherapy, thermotherapy, radiotherapy, electrotherapy and mechanotherapy are coming into greater use every year. The latest development has been the discovery of the dispensary and of its real significance in hospital practice. The out-patient department of the well regulated hospital has overshadowed and outgrown in importance the service in the wards. The out-patient department is no longer a neglected annex from which the transfer to the wards of a patient sick enough to go to bed means a complete change of doctors and a new start in the treatment of his disease.

Personal Physician to Sick Poor

The properly run out-patient service should include the admission department to the ward service for all cases; it should be also the accident ward for ambulatory and for ambulance cases; it should be the department where all cases apply first for treatment and where the largest number should continue to be treated in daily or weekly office visits with no question of such cases entering the bed service in the wards; it should be the medical adviser of all cases discharged from the wards during convalescence and in this way carry on the after care or follow-up system which has become such an important element in the tabulating of statistics, especially in post-operative surgical work.

Such a dispensary service will be forced by its contact with the wards to give careful attention to all its cases in the matter of physical examination and of treatment, both of which under the older regime were sometimes neglected until the dispensary became a real abuse. It will also force the ward services of the hospital to recognize the need and provide the beds to take care of those cases requiring hospital care among the patients suffering from diseases of the organs of special sense and of the nervous system. Such a dispensary will offer care and treatment to special groups of cases such as those suffering from heart disease, from diabetes or from tuberculosis. In this way the dispensary acts for the sick poor as a personal physician. In most cases the ward and the treatment of the disease in bed is only an incident in the course of a chronic illness and a temporary condition while the patients look to the out-patient department for the treatment of lesser ailments and for their ordinary and daily medical advice.

Very few hospitals, if any, have reached a development which cannot be further improved but some are working out their problems with an earnest will to do the best that can be done with the structural difficulties which old buildings planned for the older methods of administration force upon them. There still exist hospitals with no out-patient service at all and there are still in New York dispensaries with no hospital affiliations. Such anomalous conditions are the inheritance from the time when the interrelation of a hospital and a dispensary was not appreciated.

The discovery of the dispensary has meant as much to the professional staff as it has to the office of administration. The medical man who has limited his work to a ward service will find in the out-patient service cases which present the early symptoms of serious diseases; he will find patients who complain seemingly of lesser ailments and who present the problem of being able to work on a part-time job if they are helped. Both in the dispensary and in the wards the cur-

ing of disease is the important part of the work; in the dispensary the problem of keeping the handicapped at home, out of bed and doing the maximum amount of work of which they are capable is substituted for the duty of the ward to make the incurable and the dying as comfortable as possible. In no class of cases is the cooperation of dispensary and ward so well exemplified as in those suffering from chronic heart disease. Since the special class for heart cases has been established at the out-patient department of St. Luke's, these patients return for a course of treatment in bed at less frequent and at longer intervals. For the younger physicians the study and care of ailments of temporary duration and of minor severity can be carried on in the dispensary and will round out their experience and complete their education after they have finished their intern service.

The organization of the professional staff to attend to all the duties of indoor and out-of-door patients requires a readjustment of the present conditions existing in hospitals under the older plan. Each division of the hospital wards should have connected with it a service in the out-patient department on which attendance should be required at least for three days in the week. The physicians on duty in the wards should visit the dispensary at fixed and regular times and those whose chief work for the institution is in the dispensary should also have not only the privilege but the right to visit the wards. In no other way can the patients be cared for professionally by a single responsibility when they are transferred from ward to dispensary or vice versa. All the physicians should be on a full time service, by which is meant not the full time panacea which would engraft a monastic seclusion on hospital physicians and which is being supported under contract by large foundations and carried on in a few schools and hospitals. The whole staff of hospital physicians should be on a full time or continuous service except for necessary vacations, and at least with the possible exception only of the lower grades of assistants, all hospital physicians should serve actively in only one institution of the same character.

Organization at St. Luke's

In St. Luke's Hospital much has been done to bring the out-patient service and the wards into a close relationship. The professional staff is on continuous service and the laboratories have representatives on the clinical staff. The present arrangement can be further improved upon without doubt, and plans for the future will perfect some of the present and necessary shortcomings. It is impossible at St. Luke's, for instance, to bring about a single office of admission to dispensary and to wards, because the buildings were designed before the importance of the dispensary in the hospital organization was at all appreciated. The patients have been brought under a single professional responsibility and this chief benefit of the new ideas has been secured.

The staff is one of pyramided responsibility. There is one attending physician, who is also director of the out-patient department, and two associates, one of whom is clinical pathologist and in charge of the chemical department of the laboratories. Each of these latter then has equal right to take charge of the ward service during the vacations of his colleague. There are two assistants, one of whom is chief of clinic in the dispensary service assigned to the division and both of whom have rights to visit the wards and to oversee such educational groups of medical students as may be assigned to the division and prepare those students to accompany the associates or attending physician on formal rounds. There are an indeterminate number of assistants who work in the dispensary, most of whom are former interns of the hospital. One of these has ward rights and is in charge of the electrocardiograph, and all have the privilege of visiting the wards, especially to follow the cases sent in from their own rooms in the dispensary. And finally there is a rotating house staff of four, serving for periods of six months each, in several grades, the first in the laboratories and the last as house physician.

The two distinctive features of conducting the service are, first, general ward rounds on one morning of the week when the whole staff including the assistants from the dispensary makes a thorough clinical inspection of the wards and discusses the medical happenings of the previous week. The second and more important innovation is a weekly visit by the director, accompanied by the whole staff including the interns to the dispensary. At these visits, new cases are diagnosticated, old cases, both those formerly in the wards and also those in the dispensary, are reexamined and given the advantages of a medical consultation. The cardiac clinic meets in the dispensary twice a week, at times separate from those devoted to the general cases, and the physicians from the ward service attend these heart clinics for consultation whenever possible. This resumé of the medical organization of Division B at St. Luke's is presented not as a perfect scheme of service, but as an example of a developing and growing system which it is hoped will be still further improved in the future.

THE RECONSTRUCTION HOSPITAL: A HERITAGE FROM THE WORLD WAR

By ROBERT STUART, Superintendent, The Reconstruction Hospital, New York, N. Y.

AN OUTSTANDING advance in the solution of the problem of the rehabilitation of injured industrial employes is seen in The Reconstruction Hospital at Central Park West and 100th Street, New York.

The conception of this hospital arose from the work of the Clinic for Functional Re-education, which was established by a philanthropic founder for war service and opened July 15, 1918. The methods employed at this clinic were copied from the British, French and Canadian reconstruction hospitals, and were found so successful through a period of two years' trial that it was resolved to make them permanently available for industrial accident patients.

To this end and to enable great expansion of the work a consolidation was effected with the Demilt Dispensary (founded 1851) and the Park Hospital (founded 1902), the latter institution having also done excellent war service while known as the Red Cross Hospital. Thus a notable consolidation of three important medical institutions was accomplished through reincorporation with the new title, "The Reconstruction Hospital." With this hospital is affiliated by special resolution, the Institute for Crippled and Disabled Men. The facilities of the hospital are utilized weekly by Cornell University Medical College in teaching students.

Already Outgrown Its Quarters

The Park Hospital was the fortunate possessor of a small but excellent hospital building and of a large vacant lot adjoining it in one of the most desirable locations of the city, facing Central Park. To this hospital building the original Clinic for Re-education was moved in April, 1921, and the work of The Reconstruction Hospital has so far outgrown its quarters that a large addition has been planned and erection is under way.

The present officers of The Reconstruction Hospital are: W. Gilman Thompson, M.D., president; Allen Wardwell, chairman, board of directors; John A. Hartwell, M.D., vice-president; Giraud F. Thomson, vice-president; Edward M. Townsend, treasurer; Elwyn W. Poor, secretary; and Robert Stuart, superintendent and assistant to the president.

The Reconstruction Hospital is maintained by a volunteer board of directors and operated by a volunteer board of visiting surgeons and physicians.

Disability is rated when the patient enters and leaves the institution; stated reports are furnished of the patient's condition at regular intervals, and companies may send their own inspectors at any time for report on special cases if desired.

For Accidents and Occupation Diseases

The hospital is specialized primarily for the treatment of industrial accidents and occupation diseases. The ordinary surgical work which can be dealt with in general hospitals is not included; in other words, The Reconstruction Hospital specializes in the treatment of fractures, burns, dislocations, sprains, hernia, nerve and muscle injuries, etc., but other cases not immediately due to injury, such as appendicitis, tumors, etc., are referred to general hospitals. Occupation diseases, particularly poisons acquired in the chemical trades, occupation neuroses, etc., are in-

Weaving

Electrotherapy

cluded in the scope of the work of the hospital.

Patients receive treatment by means of specially designed apparatus and equipment. The hospital maintains a corps of operators trained in the use of these appliances, many of whom have had three years' experience in the institution, treating under the surgeons' direction the maimed soldiers and sailors of the war. Particular study is made of diagnoses before treatment is given, and whenever necessary, a patient is examined by the consulting specialists together with the visiting staff. Thus the indications for the proper treatment are determined without loss of time.

The essential feature of the whole plan of The Reconstruction Hospital is to combine all the different procedures of operative and postoperative treatment in a complete logical sequence. Many

Basketry

of the general hospitals afford facilities for individual features of treatment, but The Reconstruction Hospital has grouped all these features with an increasing success during the four years of its experience.

Aims to Prevent Dependency

The primary object of The Reconstruction Hospital is to put the industrial employe, injured through accident, back on the job in the shortest possible time and to prevent the seriously injured man from ever lapsing into the attitude of the hopeless cripple, who so often becomes wholly dependent or a beggar. To this end, he may enter the hospital immediately after injury to receive first aid treatment, subsequent restorative operation when necessary, and continued after-treatment by means of physiotherapy (baths, electricity, hot air baking, massage, special exercises, etc.). While still in bed, occupational therapy is begun, to be continued when the patient is up and about, so that although still disabled, he may make articles of substantial value which are sold for his benefit. Thus long before he is able to return to the factory or workshop, he may be earning for his family and himself. When finally discharged from the need of further surgical care, he is referred to the Institute for Crippled and Disabled Men, where he may learn a new trade if unfit for his original one, and, in any event, is aided through the special employment bureau to obtain a remunerative job.

Since July, 1918, no less than 4,041 patients have been admitted; 782 operations performed; 238,078 individual treatments given in the various branches of physiotherapy and 8,113 x-ray pictures taken.

Patients have been received from eight different departments of the federal government, from state and city departments, in addition to those referred direct from a large number of industrial concerns, both local and at considerable distances from New York. The Erie, the Pennsylvania, the New York Central, the Ontario & Western and other railroads have made extensive use of The Reconstruction Hospital in cases requiring restoration of function.

While The Reconstruction Hospital aims to serve the woman worker as well as the man, lack of space at the present time prevents handling other than woman ambulant cases, clinics for which are conducted three times a week.

The hospital has most extensive plans for making studies of occupational diseases, publishing researches in new surgical methods and training doctors and nurses for special services in industrial medicine and surgery.

Being the pioneer hospital of its kind in the country, The Reconstruction Hospital feels the responsibility for leadership in this practically untilled field of endeavor and is making every effort to shoulder its responsibility. If its past record is any indication of its future usefulness, it is safe to prophesy that this most pressing industrial problem is in the course of ultimate solution.

Visitors are welcomed at all times, and those on whom responsibility for the proper care of injured persons lies, such as railroad officials, corporation doctors, insurance company claim agents, etc., are being cordially invited to visit the hospital for personal observation of the scope and atmosphere of the entire institution. A booklet of information has been prepared which the superintendent will forward to all inquirers.

MEMORIAL TO SANATORIUM HEAD

As a memorial to the late Dr. B. L. Taliaferro, superintendent of Catawba Sanatorium, Virginia, the patients at Catawba have decided to add a Taliaferro Memorial Fund to the Tuberculosis Foundation of Virginia. The fund will provide a free bed at the sanatorium. The Virginia Tuberculosis Foundation provides funds for tuberculosis patients unable to afford sanatorium care.

HOSPITAL LINEN

By L. H. BURLINGHAM, Superintendent, Barnes Hospital, St. Louis, Mo.

IN DISCUSSING hospital linen the writer has in mind household linen used in the care of patients, such as sheets, pillow cases, spreads, washcloths, towels, tray covers, stand covers, bureau and chiffonier scarfs, gowns; materials used on dining tables, such as table cloths and napkins; certain clothing worn by employes, such as uniforms, gowns, aprons and personal apparel; in fact everything that goes to the laundry except blankets.

Some Hints in Purchasing

Purchase of hospital linen should follow the procedure usual for all hospital supplies, that is, by competitive bids. Occasionally a considerable saving can be made by speculating for a long period in advance. It is always wise to get information from an unprejudiced person (usually one not interested in making the sale), but even then in the long run it is safer and more conservative to cover one's wants for only three to four months, never more than six months. The buyer should be sure that competitors are bidding on precisely the same goods, and if there is any question should demand samples, count threads and obtain the weight of the goods per yard (after washing if starch is used as a sizing). It goes without saying that unless an article has been standardized the head of the department where the article is to be used first should be consulted, as in this way improvements can be made and a greater degree of satisfaction obtained. It is often wise to have a sample article or piece of goods passed through the laundry several times in quick succession to ascertain how well the material will stand laundering and how great is the shrinkage.

Also one should bear in mind that while quality must always be considered, too fine quality, as in towels, makes for rapid disappearance. Linen disappears in many ways, some of which are obviously theft, but it is often difficult to lay a finger on the exact method of their departure. Sheets and pillow cases do not seem so likely to disappear, so a standard brand which will wear well is best. In wash cloths, the best buy is the most reasonably priced one that is satisfactory, as they seem to disappear more rapidly than any other article of linen.

Even a fairly small hospital can keep a small sewing-room supplied with mending, and on occasion many articles can be made up more cheaply than they can be bought. This can be best determined by a study of costs of labor and material. Happy is that hospital, the linen needs of which are cared for in whole or in part by some sewing organization, enabling money that would be spent thus to be turned to other hospital needs. While speculation is not advisable there should always be a sufficient reserve supply on hand so that one is not forced to go into the market to buy to cover emergency needs.

In the care of linen, so far as possible stained linen should be used for cases that are likely to stain it, instead of spotless linen. Every hospital executive knows that even with the best of care and with the use of all kinds of stain-removers linen is apt to become stained. Every executive also knows that no one when confronted with a bureau scarf that has been used as a dust cloth confesses any knowledge of it. One simple precaution in the care of linen is to possess a supply of laundry bags of heavy material; otherwise a perfectly new spread or sheet, used as a laundry bag, will become badly ruptured by a fall of several stories down a linen chute, and badly soiled and stained by being dragged over a floor. Another precaution is to "kill the rat." Rats find their way even into absolutely new hospitals, and they seem especially fond of blood-stained linen.

The one place above all where care must be used is in the laundry, for most linen is "washed out" rather than "worn out." The first, best and greatest precaution is the use of soft water; especially fortunate is that laundry that has a supply of naturally soft water. In such a laundry by the use of a mildly alkaline soap, with careful rinsing and with the use of very little bleach or sour, linen can be washed day after day until it is in rags and still it will retain its original bright color and its sweet odor. With the advent of water-softeners, even if the water supply is hard, the same results can be obtained. The saving in supplies will soon save the original cost of the softener.

Issuance of Linen

Issuance of all hospital linen should follow the invariable rule of good hospital management for issuing supplies which is only by signed requisition from the store. Goods are requisitioned for two purposes: (1) replacement of worn-out articles turned in for exchange when beyond repair, and (2) new goods. New goods are issued when goods have disappeared and when the inventory reveals that there are less articles in circulation than a carefully determined standard shows to be

necessary. These fresh goods should be marked before they go into circulation.

A Scheme of Marking Linen

In marking linen, a hand marking machine with dies is satisfactory for many kinds of linen, though for marking small lots a type-setting machine is better. Personal linen should have name tapes sewed on, always in the same place on the same class of garments, though sometimes a pen and indelible ink will be necessary in the laundry to avoid sending articles back for marking. All linen should be dated as this gives information which may be of great value. Dating shows how well goods wear and is a guide when purchasing the same type of articles. If too many goods wear out sooner than they should, the laundry is at fault through too hard washing or the use of too much bleach or sour. Enough marks should be used to prevent unnecessary handling of goods when folded; on the other hand too much marking makes goods appear "institutionalized." There are cases where this practice is justifiable, however, to avoid the theft of articles. In general it is better to mark linen with the name of the hospital, the date, the department to which it belongs, but not the particular part of that department. The writer recommends marking sheets with the word WARD, but not with the particular ward. This allows greater flexibility in distribution, as at a given time Ward A may be quite full and Ward B nearly empty, and in a few days the condition may be reversed, so that if each had its own linen individually marked one ward would be short one day and the other ward have too much. If the linen is marked only WARD, it can be sent at once to the place where it is most needed.

Handling Soiled Linen in the Laundry

In laundering hospital linen the following points have been found valuable. Soiled linen should be sorted so as to save time for the washing machines and wear on the goods, since comparatively clean linen does not have to be subjected to the longer washing which heavily soiled linen requires. Soiled or stained linen from the operating room, delivery rooms or wards should be placed in special bags for that purpose and washed separately before being put into the washers with other laundry. Such care will eliminate much of the stained linen that may otherwise be found in general circulation in many hospitals.

An added problem in the handling of laundry in the wards is the care of linen used by patients with infectious diseases—linen which must be sterilized before it can again be used. This should be collected by the nurse at the bedside of the patient in small laundry bags made of different material than the regular bags. These bags may be collected with the regular large-sized bags containing the ordinary soiled linen. When reaching the laundry the small bags are immediately taken from the others, and the contents emptied into a washer kept particularly for this purpose, and which is so connected with live steam that the clothes may be completely sterilized in the washer before going through the regular process of washing. If this is not feasible, it may be thoroughly boiled on the ward and sent to the laundry in the regular laundry bags though this method is not so good as the previous one.

Hand ironing should be avoided whenever possible. Turkish towels and wash cloths can be satisfactorily handled by passing through a tumbler dryer and then folding. They are softer, fluffier and more absorbent than when passed through a flat-work ironer, and the flat-work ironer can usually be kept running to capacity with flat-work, gowns and aprons. Much work that was formerly done by hand can now be done on body ironers and ironer-presses, and with a little touching up by hand cannot be distinguished from all handwork, saving greatly in time.

"Laundry Square" for Personal Linen

For personal linen a room fitted with compartments for each individual is almost indispensable for accurate and rapid handling and sorting, and a laundry square for each person should be insisted on. By "laundry square" is meant a piece of heavy washable material 1¼ yards square used instead of the usual laundry bag to carry personal linen to and from the laundry. The use of this facilitates the counting and sorting of the individual linen. It also makes it possible to convey without injury certain starched articles which would be badly crushed if put into a laundry bag. Uniforms can best be placed on wooden hangers after ironing and taken in large quantities on a pole to the nurses' residence.

In a well arranged laundry the goods are received in the sorting room and from there travel a direct path through washer, extractor and finishing machine. The path should end at a set of storage shelves where the goods are starched. From these shelves the orders for the various parts of the hospital are filled directly into the delivery baskets made of wood and mounted on rubber or composition wheels. Requisitions are made out on special forms and are for only one day's supply, or for two days' when Sunday or a holiday follows.

The elimination of a linen room saves several handlings of the linen: (1) from the laundry to the truck, (2) from the truck to the shelves in the linen room, and (3) from the shelves back into the delivery basket, as these three movements are replaced by the one handling from the storage shelves in the laundry to the delivery baskets. By this system "one day service" can be maintained provided the laundry takes its half holiday on Wednesday instead of Saturday afternoon. It also makes it possible to keep in circulation only a little more than twice the daily standard of linen, instead of three times the daily standard which would be required if two-day service were maintained. Unless inspection is made from time to time, a head nurse who is either careless or over-careful, will accumulate linen on her shelves not in active circulation and some other part of the hospital will lack its required supply. It seems to be an axiom in hospital work that the greater the amount of material in circulation the greater the use and the larger the amount of loss.

All articles needing mending are withdrawn by the laundry employes, placed in a special basket and sent to the sewing room for repair. The best place for this withdrawal of flat-work is just after it has passed through the ironer and before it is folded. Power sewing machines are used to repair all that is worth while, and anything that cannot be repaired is held for discarding and replacement by the housekeeper. The material discarded can be used for patching, for cleaning rags, or if too small can be sent with other clean material to a factory to be picked up for waste cotton.

A definite standard must be set for each place supplied if the stock of linen is to be kept at a satisfactory point, that is, with neither too much nor too little in circulation. Thus each ward has a standard depending upon the number of patients and the variety of patients, as medical, surgical or obstetrical. A floor of private rooms would of course have an entirely different standard than a ward. To keep the standard filled a simple form of bookkeeping is required. Each month on a definite day an inventory is taken of all the linen in the wards and private floors on the shelves and in use on the beds, in the operating rooms and in the laundry. These can be taken on the same form of laundry list that is used for requisition. They are then turned in and totaled. The totals can then be tabulated on a ruled form and in an adjacent column the amount which has been replaced set down, so that one may know how rapidly goods are wearing out. The amount shown on the inventory is then subtracted from the standard, and this gives the amount of new linen which must be requisitioned from the storeroom. While it is difficult to get the inventory made as carefully as it should be done, still perseverance will greatly improve this work, which is a great aid to hospital economy and efficiency.

PARLIAMENT HEARS COMMITTEE'S REPORT ON MENTAL HOSPITALS

Attacks upon the administration of public mental hospitals in England, made in a recently published volume, "The Experiences of an Asylum Doctor" by Dr. Montagu Lomax, gave rise to the appointment of a committee to investigate conditions. The committee has made its full report to Parliament.

As a result of the investigation the committee found that the book draws attention to some aspects of asylum administration which have long been recognized as admitting of improvement, that many statements in the book are based on hearsay evidence or on none at all, and that many deductions are unjustified by facts. It further reported that the volume contains many "gross exaggerations" and that although Dr. Lomax attacks what he calls a "system" the committee was unable to find that any "system" producing uniformity of treatment exists. No allowance was made by the author for the quite abnormal conditions created by the war, it was said.

However, arising out of the investigation some important recommendations were made by the committee; among them were the following:

That for the future the size of mental hospitals should so far as possible be limited to accommodations for 1,000 patients.

That in classification of patients account should be taken of their home conditions.

That the superintendent of a mental hospital should be a medical man, having undivided control of the institution, and that a small advisory board, preferably associated with the board of control should be available for consultation by visiting committees when making these appointments.

That the number of assistant medical directors should be increased and that facilities for study leave be given them.

That the departmental committee on the nursing service should consider whether some distinction could be made between the two duties of mental nurses—namely, nursing proper and social duties—and that the present rigid system involving short shifts of duty should be discontinued.

Other recommendations relate to greater variety of diet, to the appointment of a special occupation officer at each institution, to the better organization of aftercare work and to the possibilities of coordination of research in a few fully-equipped institutions.

WOULD NAME COUNTY SANATORIUM FOR ITS PROMOTER

The new tuberculosis hospital in Calhoun County, Michigan, will be known as the Kimball Hospital, if a movement which is now under way is successful. Friends of the late Dr. Arthur S. Kimball of Battle Creek wish thus to honor the memory of the man who was for many years director of the Calhoun County tuberculosis clinic and who worked ceaselessly for the establishment of the county sanatorium which was recently authorized by the taxpayers.

SHOULD THE HOSPITAL PHARMACIST HAVE A PLACE ON THE PROFESSIONAL STAFF?

By EDWARD SWALLOW, Pharmacist to Out-Patient Department, Bellevue Hospital, New York.

THE great progress made in medicine during the past few years has naturally reacted upon the profession of pharmacy which now plays an important part in the practice of medicine. This applies particularly to hospital pharmacy, where the pharmacist is brought into the closest relations with the physicians and surgeons.

In the hospital the pharmacist is purely a professional man as he is called upon to practice only his art and science in carrying out the requirements of the medical men. His profession demands knowledge of no mean order, skill and integrity, and he is engaged in a calling in which there is a well defined legal and moral duty and an obligation toward public health and life. He deserves all the honor and dignity possible in his important calling; yet we find that in very few hospitals is the pharmacist on the professional staff. His proper place would seem to be on the house staff among the other professional men such as the resident physicians. In the great majority of hopitals the pharmacist though a professional man is upon the administrative staff where he does not rightfully belong.

Accuracy and Watchfulness Essential

Grave responsibilities rest upon the shoulders of the hospital pharmacist who not only has to exercise constant vigilance in compounding and preparing the medications but also has to see to it that nothing goes into the wards which has lost its virtue by any form of deterioration.

Accuracy and watchfulness are absolutely essential in the hospital pharmacy all the time as the life and health of the patient are at stake and any deviation from the doctor's orders is likely to effect the treatment seriously.

The hospital pharmacist is there to give the medical men his professional services; he should work with all his ability and art according to the highest ethics and honor so as to reflect credit and dignity on his profession, and enable patients to reap every advantage from the physician's knowledge and experience. Slipshod, inaccurate methods of performing his duties react unfavorably on the good repute and professional ability of the physician, and endanger the health and safety of the patient who is apt to judge the value of the medical service by the quality of the medicine prescribed.

The rapid increase in the number of hospitals and their fuller development will bring the hospital pharmacist into still closer relations with the physicians and nurses, making his profession of increasing importance to hospitals and the public.

Pharmacist Instructs Nurses

In a few hospitals the pharmacist is called upon to give instruction to the nurses, and in the near future this will form part of his duties as he is peculiarly qualified in every way to impart much useful knowledge, both theoretical and practical, to the hospital nurses who thoroughly appreciate its importance in their calling.

In fact hospital pharmacy is rapidly enlarging its scope and its possibilities, and, recognizing this, some hospital pharmacists who are members of the American Pharmaceutical Association have formed a special group within the association devoted to the interests of hospital pharmacy, the solving of problems, the exchange of formulas, etc., with the idea of improving and increasing the importance of the pharmacy department in American hospitals. This means better service to the hospitals by the pharmacists and shows worthy desire to meet all the requirements of the medical profession in the spirit of helpfulness.

The American Pharmaceutical Association, recognizing the purely professional activities of the hospital pharmacist, is giving to each one who has not become a member an invitation to join in the aspirations and attainments which the association strives after for the uplift of pharmacy, the comity of relations between physicians and pharmacists and the benefit of mankind.

SOME SUPERLATIVES

The greatest sin is FEAR.
The best day—TODAY.
The greatest mistake—GIVING UP.
The most expensive indulgence—HATE.
The greatest trouble maker—TALKING TOO MUCH.
The best teacher—ONE WHO MAKES YOU WANT TO LEARN.
The best part of religion—GENTLENESS AND CHEERFULNESS.
The meanest feeling—JEALOUSY.
The greatest need—COMMON SENSE.
The cheapest, stupidest and easiest thing to do—FINDING FAULT.
The best gift—FORGIVENESS.

—Dr. Frank Crane.

THE NEW EVANGELICAL DEACONESS' AND NURSES' HOME IN CHICAGO

By BISHOP SAMUEL P. SPRENG, D.D. Chairman, Board of Directors, Naperville, Ill.

THE Deaconess Society of the Evangelical Association, a religious denomination, was organized by authority of the general conference in 1903. Its primary purpose is the training and employment of deaconesses for Christian service, and believing that a deaconess should be a trained nurse for the proper care of the sick, as well as a social and religious worker, a hospital was soon erected in Chicago as a part of this training school. Nurses were later on also admitted for training, and the training school of the Deaconess Society became also a training school for nurses, accredited under the state board of Illinois.

From the beginning the housing and care of nurses in training as well as the deaconesses became a serious problem. The Society lacked the facilities for giving the students proper home conditions. Many of the girls came from the better class of homes and were accustomed to modern conveniences and comforts, to say nothing of pleasant and attractive surroundings. Away from these, many of them became homesick. The experience in the unwonted atmosphere of the hospital made them long the more for something like home life and comfort when off duty. It was this, and the conviction that a wholesome morale is essential to the best results in study and service, that led the Society to plan for the erection of a suitable home for these girls, and one which would also ultimately provide a comfortable place for aged deaconesses and for those who by illness have become incapacitated for service.

The Evangelical Deaconess and Nurses' Home

Ground was accordingly purchased one half block west of the hospital on Wisconsin street and a block from the street car line. The location is quite near the beautiful Lincoln Park. Here the new home was erected in 1920-21 on the corner of Wisconsin and Hudson streets. The new hospital building, which is being planned, will be erected just across the street. The plans were drawn by the architect, H. E. Pridmore, who also superintended the erection of the building.

The residence is a stately modern building, practically four stories high, and occupies a ground space of 105x44 feet. From the standpoint of design and construction it represents perhaps one of the most up-to-date nurses' homes in the country. The facade is an adaptation of Colonial architecture carried out in tapestry brick and laid in Flemish bond, with a liberal use of cream colored terra cotta trimming, including the arch over the main entrance and heavy cornice the whole length of the building. The structure is fireproof throughout.

Floors and interior supported columns are constructed of reinforced concrete, the open joist system being employed. The floors throughout are finished smoothly in cement, no wood being used. On top they are coated with a patented binding solution to prevent the accumulation of dust, thus making the floors sanitary and easily kept clean. The entire walls and ceilings are finished in a hard plaster, applied on expanded metal lath.

One unusual feature of the building is the generous modern facilities, which the building committee insisted on providing for the nurses. There is a toilet, lavatory and bath between each pair of bedrooms, the bath being in a separate compartment, thus giving the maximum utility and at the same time privacy. In fact the conveniences are equal to those in a first class modern hotel.

The arrangement of the first floor provides a reception room off the entrance hall. At the southeast corner the principal has a private suite of three rooms, a living room, bedroom and bath. Next to this suite is a private room provided with all conveniences for the assistant principal. There are also good accommodations for the matron. Another attractive feature on this floor is a small kitchen and dining room adjoining, for the use of

Looking down the attractive living room.

A student nurse's room.

deaconesses and nurses. This is so arranged that when off duty they may prepare refreshments for themselves. A splendid living room at the west extends across the entire width of the building; it is tastefully decorated, has panelled ceilings and walls and a fine large mantle and fireplace at the north end. The room is elegantly and massively furnished and well lighted. Opening into it is a spacious library with bookcases, reading lamps and tables.

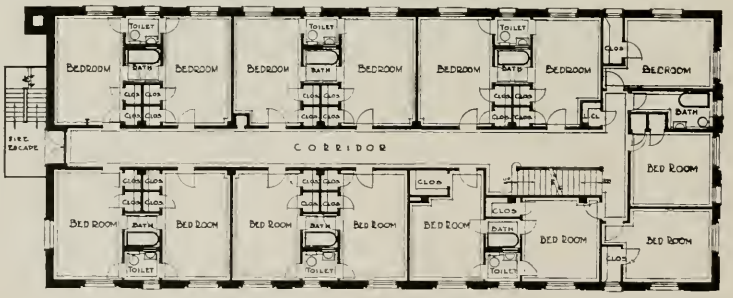
Provides Gymnasium Facilities

The building has a high and commodious basement. Here again the comfort of the girls has been given first consideration. Stretching across the east end is a gymnasium, the floor of which is several feet lower than the rest of the basement in order to give the proper height. This room is provided with an abundance of light and air. Adjoining are shower baths and toilets. The central portion of the basement area contains ample trunk rooms and storage facilities. There are also special quarters for the use of the janitor and fireman. The boiler room, coal room, etc., occupies the west end of the basement. Heating is furnished by means of a hot water system.

New Hospital Being Planned

The entire building, both as to its interior and exterior, is characterized by simplicity, symmetry, beauty and utility. It leaves little to be desired. The management is convinced that the home has already contributed much to the contentment, the efficiency and the happiness of deaconesses, nurses and students in training.

The Society is now planning the erection of its long contemplated and greatly needed new hospital. This also will be erected on Wisconsin street. In architectural design it will harmonize with that of the home, will have a capacity of 100 beds, and will be modern and up-to-date in every particular.



Typical floor plan of Evangelical Deaconess and Nurses' Home.

HEADS FARGO HOSPITAL

Mrs. G. W. Fuller, R.N., has been appointed superintendent of St. Luke's Hospital at Fargo, N. D., to succeed A. O. Fonkalsrud, who resigned in June. Mrs. Fuller is a graduate of St. Luke's Hospital, St. Paul, Mr. Fonkalsrud is at Minot, N. D.

An Announcement

The Modern Hospital Publishing Co., Inc., announces a competition for plans of a

Small Community Hospital

in order to stimulate a greater interest in the construction of economically arranged and architecturally artistic hospitals, and in order to provide boards of trustees of small institutions with a group of suggestive plans that will make for more efficient care and treatment of the sick.

$1,000 in Prizes

will be given to architects through the competition, the general program of which was announced at the twenty-fourth annual conference of the American Hospital Association at Atlantic City, September 25-28. Three cash prizes of $500, $300 and $200 will be awarded, and two honorable mentions made.

The detailed program for the competition is given on pages 313-315 of this issue.

The MODERN HOSPITAL

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ANOTHER YEAR

THE twenty-fourth annual conference of the American Hospital Association has come and gone. Our comments, commendatory and critical, will be found on another page. Our interest now lies in the future and as we turn our thought in this direction we find cause for encouragement in Mr. Bacon's address of acceptance of the office of president. It is evident he intends to make the coming year one of accomplishment for the American Hospital Association. He says specifically, "Where there is no growth and development, there is deterioration." Mr. Bacon has the interests of the American Hospital Association too much at heart to tolerate disintegration; consequently we may, with good reason, look for growth, perhaps rapid growth. There will undoubtedly be marked growth in the membership of the association, both personal and institutional. There will be growth in the number of service bureaus, if an additional number is needed to serve the field effectively. Especially will there be growth in the number and activities of state and provincial associations, and where individual state associations are not feasible, geographical sections, in order that all of the United States and Canada may be fully organized to work as individual units or together, as needs may dictate, for proper laws and standards for the prevention of disease and the care of the sick.

Mr. Bacon's standing committees for the coming year were announced before the convention adjourned, and we understand that much of the program of next year's conference is already mapped out and ready to be acted upon as soon as the association and board of trustees decide upon the time and place. We believe Mr. Bacon will translate the spirit of his presidential address into action, and that we may look forward to one of the association's most fruitful years.

A SUBSTITUTE FOR THE MISSING INTERN

THE normal activities of the intern have an important bearing on the quality of hospital service. Hospitals which are deprived of the services of interns labor under a handicap, and may easily be frustrated in any attempt at the proper organization and standardization of their clinical work. An inquiry made by THE MODERN HOSPITAL in 1919 showed how many of the smaller hospitals of the country were without interns, and how keenly the need of them was felt. It was hoped that the inquiry would be followed speedily by the training of a group of non-medical women to serve as substitutes for interns where no interns were available, but that hope has not yet been realized.

It is futile to talk about perfecting the clinical records of small hospitals, unless some one can be brought into the service of such hospitals who is capable in some degree of taking the place of the missing intern. The shortage of interns was greatly accentuated during the war, but the underlying conditions are such that the cessation of the war did not bring adequate relief; the number of hospital beds and the demand for services incidental to the diagnosis and treatment of hospital patients, have increased and are still increasing at a rate far beyond the rate of increase in the number of graduating medical students. The American Medical Association has shown that the medical schools of today are prepared to graduate only about one-half the number of men that could be used to advantage as interns in the six or seven hundred hospitals that are approved by the association as possessing the necessary equipment and qualifications for the training of interns; and here no account is taken of the immensely greater number of institutions that do not possess such qualifications.

With the best will in the world, the visiting staffs of hospitals that have no interns cannot see

patients promptly enough after the arrival of the patients in the hospital; they cannot take proper histories, record operations satisfactorily, secure adequate and timely assistance at operations, render prompt first aid in minor accident cases, make adequate clinical notes, make urinary analyses and blood examinations with reasonable frequency, or give suitable attention to infected wounds which require time-consuming treatment. For all this work resident assistants are needed.

The solution of the problems which was suggested in these columns three years ago is the inauguration of a course of training for non-medical clinical aids. Women have been intensively trained and are being successfully used as anesthetists and as laboratory technicians, but such women have been trained to serve exclusively in the capacities named and are not qualified for the broader work of clinical aids; moreover, most of the women who have taken this special training have been rapidly absorbed by the larger hospitals as a supplement to the intern staff, and have brought no relief to the smaller institutions that have no staff of interns to be relieved or helped out in this way.

In from twelve to eighteen months an intelligent graduate nurse can be taught to perform all that part of an intern's work which does not involve diagnosis and treatment, except perhaps some of the more difficult laboratory and bedside procedures. An appropriate course of training would include Anesthesia, First Aid, Surgical Dressings, Laboratory Technique, History Taking, Technique of the Operating Room, and Clinical Records, to which might be added optional courses in stenography and typewriting. A carefully chosen committee could easily map out the details of such a course, which could then be given as post-graduate instruction in schools of nursing associated with hospitals possessing sufficiently varied and extensive clinical and laboratory resources. It is hoped that this suggestion will soon assume practical shape, and that it will receive the vigorous support of the medical profession, for a competent substitute for the missing intern would be a godsend to the smaller hospitals.—S. S. Goldwater, M. D.

TRUE COOPERATION IN HOSPITAL ADMINISTRATION

OF ALL the hard-worked words in our language, with the exception of poor old, threadbare "efficiency," none is more abused than "cooperation." It is the shibboloth for every movement from birth control to Old Home Week. "Cooperation is promised." "Cooperation wins the day." "He will (won't, must) cooperate." Every change is rung on this once virile, useful word until it has almost been reduced to the level of the argot, a jargonesque shadow of its former self.

Yet it is a good word when used in its correct sense, "to work with." Too frequently, it is employed to express the thought "to work for." On the contrary, it means "to work together," "to work hand-in-hand and side-by-side," "to labor collectively for a common end."

First of all cooperation means that all parties common to the job shall be on it; not that one fellow shall do a little bossing and then excuse himself to shoot a round of golf, while the others continue to pile into the work. Furthermore, it conveys the thought that they shall work together, each one on his own part of the task, and, if that particular gang is ever again to be induced to attack a similar task with the same sprightly verve, that there shall be an equitable division of the results of their cooperative toil.

There is another factor. Everybody on the job must know what end is aimed at if his work is to be done in intelligent coordination with others and equally should have an opportunity of self-expression if the product is to be really workmanlike and artistic in the true sense.

Everybody on the work in hand must be genuinely interested, hence the boss must keep the workman's viewpoint carefully in mind; in other words he must keep his eye on the morale. Cooperation is teamwork, the old "one for all and all for one" words set to modern music.

Of all the collective efforts of man, there is probably none where true cooperation counts for more than in hospital administration. The superintendent who drives his people along cannot achieve the results of the man who leads them, because to lead them he must get down off his pedestal and walk with them. He must cooperate with them if he wishes them to cooperate with him. The manager who says, "I can't get him to cooperate," is nine times out of ten unwittingly confessing that he himself won't cooperate, which is the same thing as saying that he lacks loyalty and hence cannot inspire it in others.

This idea goes all through the little community which is the hospital. A green probationer will have the meanest old grouch in the chronic ward fairly hunting for jobs to do, while the head nurse will be obeyed but grudgingly. One training school will run as smoothly as a well-oiled machine; another will be in a turmoil of discontent. Remove the cooperant from the one and the disoperant from the other and all will be changed. One surgeon will receive only the scant measure of just

service, while another, not his professional equal by half perhaps, will find interns, nurses and orderlies striving for the opportunity to work with him. The one has the quality of coherency, of drawing people about him. He is a cooperant. The other is a repellant, disbursive force. He is a disoperant.

The great enemy of real cooperation is an exalted ego. Like Bimi, it is a case of "too much ego in his cosmos." This begets forgetfulness of the fact that loyalty is perpendicular and must therefore run down as well as up. It induces a myopia to the human element in toil. Men can be brought to love almost any job because they transfer to it their affection for the boss with whom they are cooperating. Equally, and far more easily, they can acquire a bitter hatred of the job because they detest the man over them.

The Frenchman who counseled that one should put himself in the other fellow's skin had a pretty accurate notion of true cooperation.

THE EXTRA PAIR OF TROUSERS

WHEN we learn of concerns contributing to hospitals with whom they seek to do business, we are reminded of the old style of clothing merchant who found it necessary to throw in an extra pair of trousers in order to sell a suit of clothes. This particular species of merchant is not altogether extinct even now, but he is usually not numbered among the progressive and reliable merchants of the town who conduct their business on sound business principles. Of course, the merchant who offers the extra pair of trousers is in business to make a profit, and in one way or another the purchaser pays for the trousers; it could not well be otherwise. Are the hospitals so foolish as to think that in accepting contributions from merchants at large, they are really getting a pair of trousers for nothing. We are loathe to think so, for when contributions are made a matter of compulsion instead of generosity they defeat the very purpose for which they were intended. The continuance of this practice simply postpones the day of sound business administration among hospitals and encourages unscrupulous practices at the expense of honest manufacturers and merchants.

THE LIMITS OF HUMAN VERSATILITY

NO OTHER field exists in which so great a variety of merchandise must be selected and purchased by a single individual as in the hospital. The range of products runs the entire commodity gamut: structural materials and laundry supplies; foodstuffs in greater variety than needed in the modern hotel and with more exacting problems of food service; every conceivable type of general furnishings, overtopped by clinical and scientific requirements of varied nature; needles for the sewing room; coal for the furnace; soaps and cleansers; in some instances, even garden and farm equipment.

The range of exact knowledge necessary on the part of the hospital executive responsible for the purchase of these widely varied products wellnigh exceeds the limits of human versatility.

In the larger institutions comprehensive buying records often supply a proper background; in the smaller hospitals the problem is too often solved by orders being placed without proper knowledge, resulting in needless waste and obvious inefficiency.

Because of a clear recognition of these purchasing problems of the hospital, THE MODERN HOSPITAL YEAR BOOK was conceived and developed. Through this volume, information is at once available as to suitable sources of supply for practically every item used in the construction, equipment and operation of a hospital. The far-sighted, progressive superintendent will at once recognize the practical value of this extensive information; its use will be a constant aid to more efficient and economical purchasing.

The third edition of the YEAR BOOK, which is now being distributed, is a veritable encyclopedia of purchasing information in compact and usable form.

STRASBOURG MEDICAL FACULTY VISITS U. S. HOSPITALS

A delegation of members of the faculty of the medical school of the University of Strasbourg, Alsace, is in the United States as the guests of the Rockefeller Foundation for the purpose of studying the organization and methods of American medical schools.

The University of Strasbourg as organized under the French, although still in its formative stage, is one of the most important medical schools in France. In making this trip, which includes England as well as the United States, the Strasbourg faculty will have an opportunity for an exchange of ideas and a comparison of methods in medical education.

The visiting commission is made up of the dean, Dr. Georges Weiss, professor of biophysics, and six other influential members of the faculty, representing both laboratory and clinical branches—Dr. Léon Blum, professor of clinical medicine; Dr. Paul Bouin, professor of histology; Dr. Camille Duverger, professor of ophthalmology; Dr. P. Masson, professor of pathological anatomy; Dr. Maurice Nicloux, professor of physiological chemistry; and Dr. Lucien Pautrier, professor of dermatology and head of cutaneous diseases clinic.

After a brief stay in New York members of the commission, following their special interests, will visit a few of the leading institutons for medical teaching and research in the United States.

TWENTY-FOURTH CONFERENCE EMPHASIZES THE EDUCATIONAL FEATURES OF EXPOSITION

IT IS safe to say that delegates and exhibitors alike left the twenty-fourth annual convention of the American Hospital Association feeling that the exhibit of equipment and supplies was by far the best the association has ever had. Space was ample and well suited to its purpose. The exhibits were attractively arranged and the program provided ample time for their inspection, quite in contrast to last year's arrangement.

The effort to tie the exposition up more closely with the association through various exposition committees and their reports, while partially successful, fell far short of being the success anticipated by those who sponsored the idea. This, however, was far from being the fault of the exposition committees or their chairmen. The reports of these committees were admirable and gave evidence of careful preparation. They contained little, however, that related to the actual exhibits at the convention; they were rather in the nature of formal papers on the subjects the committees were asked to survey. To give the delegates full advantage of these reports, they were scheduled to be read at the second and third general sessions of the conference, but unfortunately some of them were not submitted until Wednesday and one was left until the closing day of the convention, despite the fact that the chairmen of all of the committees were present and had their reports ready for submission Tuesday morning. It is regrettable that the plan was not carried out as originally conceived.

Practical Problems Received Chief Emphasis

There were some who felt that too much of the time of the convention was devoted to the exposition and to the various reports on the physical equipment and management of the hospital and too little to some of the broader questions now agitating the hospital field. There is doubtless some ground for this criticism. The pendulum, having swung too far in one direction at the Montreal meeting, swung perhaps a little too far in the opposite at this conference. Another year may see the convention strike a happy medium. Perhaps one way to gain this desirable end would be to have the more formal parts of the reports of the exposition committees distributed in leaflet form, leaving time free for the committees' informal presentation of the noteworthy features of the exposition, as well as for a few more papers on other aspects of the field.

Like the West Baden convention, the Atlantic City conference was characterized by two or three definite accomplishments. Hospital administrators, trustee's and architects will be especially grateful for the admirable report on flooring submitted by Mr. Frank E. Chapman, its chairman. The report was supplemented by a very illuminating exhibit, showing the manner in which various flooring materials stood up under the actual tests made by the committee. A very helpful report, supplemented by an exhibit, was also submitted by the committee for the renovation of gauze, of which Dr. A. B. Denison was chairman.

To Have Committee on Accounting

The convention took positive action on but one subject—the appointment of a committee on hospital auditing and accounting. Feeling that the proper functioning of such a committee would entail too great expense, the resolutions committee

THE NEW SLATE

President

Asa S. Bacon, Presbyterian Hospital, Chicago.

President-Elect

Malcolm T. MacEachern, M.D., Vancouver General Hospital, Vancouver, B. C.

First Vice President

A. K. Haywood, M.D., Montreal General Hospital, Montreal, Quebec.

Second Vice President

Miss Charlotte A. Aikens, Detroit, Mich.

Third Vice President

R. G. Broderick, M.D., Alameda County General Hospital, San Leandro, Cal.

Treasurer

Robert J. Wilson, M.D., Health Department Hospitals, New York.

Trustees

The Rev. Maurice F. Griffin, St. Elizabeth's Hospital, Youngstown, Ohio.

A. C. Bachmeyer, M.D., Cincinnati General Hospital, Cincinnati, Ohio.

suggested the appointment of a committee to take this matter under consideration during the year and undertake such activities as would not for the present involve the association in additional expense. The section on trustees also placed itself on record as opposing the diversion of portions of legacies to hospitals, homes and other charitable or religious organizations for state purposes through the means of a collateral inheritance tax or in any other manner.

Acting on the suggestion of a small group of hospital trustees which met at the West Baden conference the board of trustees of the American Hospital Association established a section on trustees. This section held its first meeting at Atlantic City. Some seventy-five trustees and superintendents were in attendance and a number of important questions were discussed informally. The full significance of this first meeting of the section on trustees is not realized; time alone will reveal it. As an association of institutions rather than of superintendents the American Hospital Association must increasingly command the interest and support of hospital trustees. Last year's informal meeting marked the beginning of this metamorphis.

Mr. Bacon, the incoming president, with Mrs. Bacon and a friend approach the Million Dollar Pier.

One of the most helpful features of the West Baden convention was the active reception committee of the Indiana Hospital Association, which among other things made it its business to see that delegates wishing to meet each other received the necessary introductions. This feature of the Atlantic City convention was conspicuous by its absence and was made the subject of criticism at the closing session. The need for a reception committee, one of whose functions would be to introduce delegates to each other, was greater at Atlantic City than at West Baden. Since to many the chief value of these conferences lies in social contact and informal discussion it is hoped incoming officers will give this subject the consideration it deserves, and work out some practical plan under which delegates who desire to meet each other may do so easily.

The round table discussion was handled well by Mr. Asa S. Bacon. Delegates were definitely designated to lead the discussions and in the absence of further comment the chairman passed promptly to the next question. Under this plan a goodly number of questions were discussed during the time assigned to the round table and there was little lapse of interest.

Those who were responsible for the non-commercial exhibits are to be congratulated upon the attractive showing they made. These exhibits were a splendid addition to the exposition; that of the American Association of Occupational Therapy was especially noteworthy, being the largest and most diversified exhibit of its kind ever shown at an annual convention.

Association Is Truly International

Since the membership of the association is made up of citizens and institutions of both the United States and Canada, the association is international in character; it is especially fitting therefore that both countries were represented in the decorations in the main assembly hall by their flags. The association did well, moreover, to give further emphasis to the international character and scope of its work by naming Dr. Malcolm T. MacEachern as its president-elect. Dr. MacEachern is a forward-looking executive, a tireless worker and one who has the interests of the association very much at heart. With Mr. Bacon and Dr. MacEachern as its chief officers, the association has every reason to look forward to two years of constructive work.

HOLD MODEL CARDIAC CLINIC

Fifty persons witnessed the model cardiac clinics held daily in the booth of the New York Association for the Prevention and Relief of Heart Disease. The clinics were put on in cooperation with the Committee on Out-Patient Work. The clinics showed the procedure from the time the child was admitted to the institution until his discharge.

Of interest to those interested in the treatment of heart disease was the demonstration of a polygraph or pulse wave recorder with a typical heart case.

A representative of the Philadelphia Association for the Prevention and Relief of Heart Disease was present in the booth and answered inquiries about the several cardiac clinics in operation in Philadelphia hospitals.

SOME FAMILIAR FIGURES WITHOUT AS WELL AS WITHIN CONVENTION HALL

(1), J. M. Evans; (2) Dr. Joseph H. Morrow; (3), Dr. Easton (right); (4), Dr. C. S. Woods and Frank E. Brooke; (5), Dr. D. H. Fuller; (6), Walter H. Conley and Mrs. Conley; (7), Dr. J. D. Spelman and Frank E. Chapman; (8) Dr. McGuire; (9) Reuben O'Brien and Dr. Glennon; (10), Luther H. Lewis, Dr. W. P. Morrill, and an exhibitor; (11), Dr. Nevin; (12), Father O'Connell and Howell Wright; (13), Dr. L. H. Burlingham; (14), Dr. S. B. Ragsdale and Dr. Harold W. Hersey; (15), Richard P. Borden (left); (16), Henry C. Wright (center); (17), Dr. C. W. Munger and E. S. Gilmore.

THE STORY OF THE CONVENTION

THE opening general session of the twenty-fourth annual conference of the American Hospital Association was called to order by President George D. O'Hanlon, superintendent of Bellevue and Allied Hospitals of New York, at 2:30 Monday afternoon in the theater on Young's Million Dollar Pier. Following an invocation by the Rev. J. H. Robinson of Christ's Hospital, Cincinnati, Dr. J. J. Mooney of Jersey City, speaking on behalf of Governor Edwards of New Jersey, welcomed the delegates to Atlantic City and the state of New Jersey and expressed the hope that their stay would be enjoyable and that the meeting would have far reaching results.

Taking as his title "The Great Question," Doctor O'Hanlon in his presidential address, which will be found on page 269 of this issue, traced the growing activities of the American Hospital Association since its inception, reviewed some of the activities of the association's board of trustees during the past year and made a plea for hospitals as centers for social service, the development of after-care work and the extension of out-patient service.

The report of the trustees, (page 316) was read by Mr. Richard P. Borden of Union Hospital, Fall River, Mass. This report was followed by that of the treasurer, which showed that the association has a balance as of September 1 of $3,622.34. The report of the executive secretary followed and will be found on page 317 of this issue. The report of the membership committee showed that as of September 1 the association had a total institutional membership of 473 and a total personal membership of 1,543. The committee called special attention to the constitutional provision creating associate institutional membership and expressed its belief that it is to the best interests of every hospital and every hospital executive that all organizations connected with hospitals affiliate themselves with the American Hospital Association as associate institutional members, thus receiving the literature sent out by the association and obtaining the trend of thought and action as expressed in and through the association. This report will be found on page 318.

Following the report of the membership committee, Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, submitted the second report of the committee on hospital forms and records with particular reference to annual reports. In this report, (page 325) the committee submitted an outline of a standardized report and recommended that, in the absence of a uniform medical nomenclature, the publication at this time of medical statistics in hospital reports should be omitted and that a committee of representatives of interested national organizations be formed for the purpose of establishing a standardized medical nomenclature. The committee has been continued for another year and will submit a final report at the next convention.

In the absence of the chairman of the legislative committee, Dr. C. G. Parnall, medical director of the University Hospital, Ann Arbor, Mich., the report of this committee was not submitted.

President-elect M. T. MacEachern on the Boardwalk. He looks happy.

In submitting his report as chairman of the committee on relations between hospitals and states and cities, Mr. John E. Ransom, superintendent of Michael Reese Dispensary, Chicago, stated that the committee was not prepared to submit its final report to the association, but would make a detailed report some time during the coming year. Data thus far collected, however, indicated that states and cities, with few exceptions, are not concerning themselves with the regulating of hospitals. Yet regulation is in effect in some of our states and cities, and laws affecting hospitals may be passed in almost any state at any session of the legislature.

The committee is of the opinion that the hospitals of the state should be in a position to act intelligently and effectively toward any proposed legislation or the rulings of any of the state boards affecting hospitals. In order that they can so act two things seem essential. One is the establishment of the already authorized legislative service bureau of the association. The other is the organization in each commonwealth of a state hospital association as a geographical section of the American Hospital Association. The legislative service bureau can make available for the hospitals in any state the experiences of those in other states. Through a state association and only through such an organization can the hospitals of a state make use of such service on the part of the association and secure the hearing which they deserve when matters in which they are vitally concerned are receiving consideration by legislatures, city councils, state boards and other public bodies.

The committee was continued until it can make its final report to the trustees of the association.

Contest for Plans of Small Hospital

The session closed with an announcement that The Modern Hospital Publishing Co. Inc., will hold an architectural competition for the plans of small hospitals and that prizes in the amount of $1,000 will be awarded to three contestants whose plans are adjudged to be the best.

A complete program of this competition will be found on page 313 of this issue.

Flooring Report Highly Praised

The scientific evaluation of flooring materials made by Mr. F. E. Chapman, director of Mount Sinai Hospital, Cleveland, in the report of his committee on floors was most warmly commended, following its presentation on Monday evening. Throughout that day and during the entire convention, Mr. Chapman's exhibit of flooring samples in the exposition hall was the object of close study and considerable comment. At a suggestion from the convention floor these samples will be retained and Mr. Chapman's committee will extend its work throughout the coming year, adding new samples which have been given his laboratory test.

The report presented is abstracted with some fullness on page 319 of this issue.

Interesting discussion followed the reading of the report. In commenting upon it Edward F. Stevens, Boston architect, said the report would be of great benefit to men of his profession in pointing out to superintendents the necessity of having the best possible floor regardless of the initial cost. Much, however, depends upon the care given any particular floor, in his opinion. In answering Mr. Stevens, Mr. Chapman declared he would put the emphasis rather on the method of laying the floor than the care given it.

"It is time," said Mr. Chapman, "to stop selling flooring material by the yard but to sell it by years of service. The place to sell a floor is not in the store but in the hospital."

Favorable comment on the report was made in subsequent discussion by Architects Charles Butler of New York, Perry W. Swern of Chicago, W. W. Rawson of Ogden, Utah, and C. F. Owsley of Youngstown, Ohio.

Mr. Swern suggested the advisability of drawing up standard specifications for the flooring samples, as a method of avoiding samples not representative of the usual run of the product. This followed Mr. Chapman's frank admission that he believed the terrazzo samples in his exhibit were of a higher grade and stood the tests better than this type of flooring often does in actual operation.

Champions of terrazzo who testified in its behalf were E. S. Gilmore of Wesley Memorial Hospital, Chicago, and the superintendent of a Memphis institution. The concensus of opinion was the terrazzo would crack under wear unless it was laid in squares with brass strips.

The wooden floor, cognizance of which was not taken in the report owing to the unreliability of samples, was warmly defended by Architect Owsley. Mr. Chapman unqualifiedly condemned wooden floors for any general use because, he said, they are not fireproof and frequent resurfacing prevents their constant availability.

Dr. R. G. Brodrick is the new third vice-president. He thought Atlantic City too distant from California and was present in spirit only.

In calling the section on construction to order, the chairman, E. S. Gilmore, outlined some of the considerations to be made in planning the modern hospital; among them were economy, site, fire protection, beauty of architecture, space for laboratory, provision for expansion and comfort for patients, doctors and nurses.

Dr. S. S. Goldwater as chairman of the committee on buildings—construction, equipment and maintenance—presented a comprehensive report on present tendencies and practices in that field. His enumeration of current practices showed some decided changes in emphasis in many departments and structural features of the hospital. The full report of his committee will be found on page 327.

A question box on construction concluded the first evening's program and although the queries submitted touched on a variety of practical subjects, many of them went begging for an answer. In explanation of this at the conclusion of the program, Dr. Goldwater stated that all construction questions must be decided for each particular hospital, their determination resting upon the analysis of conditions peculiar to that single situation.

Advice was sought by the questioners on the proper location of kitchen, pathological laboratories, x-ray laboratories, operating room, on the price of fireproof and semi-fireproof construction and a variety of practical subjects.

As to color of operating room walls, the statement of C. J. Cumming of the Tacoma (Wash.) General Hospital that a pale gray best served his institution went unchallenged. Dr. Zulich of Easton, Pa. declared that the pathological laboratory should be near the operating room for purposes of hasty examination. Mr. Swern, Chicago architect, furnished the information that it costs 56 cents per cubic foot for fireproof construction in Chicago; in Wisconsin he had found the cost as low as 50 cents. Mr. Lewis, architect of New York, declared small wards, arranged for easy communication with the sink rooms, were preferable to large wards, this arrangement providing the efficiency of ward treatment with the privacy of the private room. Dr. Goldwater expressed the opinion that when the out-patient service of a hospital is large, the x-ray laboratory should not be placed on the operating floor, thus bringing dispensary patients who are large patrons of the x-ray laboratory near the surgical suite. The consensus of opinion seemed to be that blanket warmers should be provided for each ward, although not many of the superintendents expressed themselves as having such an arrangement.

Thus went the round table on construction, with no answers more than suggestions and most remarks qualified by the statement that the principle could not be applied universally.

Dr. Baldy Explains State Venture

The second day's session opened with an account of Pennsylvania's system of checking up hospitals which receive state aid, presented by Dr. John M. Baldy, director of the Pennsylvania department of public welfare and author of the scheme. Dr. Baldy declares that the end of the first year's trial of this control will see the saving of hundreds of thousands of dollars of state funds.

"To get the fakers" is the primary purpose of this elaborate and minutely worked out scheme for checking up the charity work of Pennsylvania hospitals. In common with most hospitals, Dr. Baldy declared, the institutions of

Studies in out-patient service were graphically illustrated in the exhibit of the Committee on Dispensary Development of New York. Photographs of Cornell Clinic, tabulated material on dispensary service and other interesting charts were on display.

Where the model cardiac clinics were held each day. These were under the direction of the Association for the Prevention and Relief of Heart Disease of New York City. Charts and statistical data decorated the booth.

that state were loaded down with free patients who should not have been objects of strict charity. With the new system, with its triple function of accounting, credit and audit, the welfare department hopes not only to deny the use of state funds to those who do not need charity but to place worthy persons, who have too much pride to admit their poverty, in free beds without humiliating them.

Credit Department Makes Hospital Pay

"At the end of the year," said Dr. Baldy, "our state will know just what it costs to maintain a poor adult in a hospital. By installing this basic bookkeeping system, an essential to any business, in each hospital receiving state aid, the welfare department and hospital superintendents can tell at a glance what every department and every subdivision of each institution costs. Already the per capita cost of maintaining a poor patient has dropped and several institutions have so lowered their costs that they can meet expenses without state assistance. It has shown that scientific departments can be made to pay and that the hospital with a credit department, properly run, can soon be on Easy Street."

More Patients Pay Their Way

Commenting on Dr. Baldy's address, Mr. Frederick D. Green, secretary of the United Hospital Fund of New York, pointed out that ten years ago 38 per cent of the hospitals were members of this fund, while in 1920 the percentage was reduced to twenty per cent, and that whereas ten years ago 18 per cent of the patients paid all or part of the hospital charges, in 1921 45 per cent paid part or all of these charges, with the result that funds were released for other needy cases and reduced the burden of the taxpayer.

Mr. Franke E. Brooke, superintendent of the Harrisburg hospital, stated that it was his practice to tell patients at the outset what was in store for them as to the payment of their bills and also pointed out the desirability in compensation cases of taking up the hospital's claim personally with the business concerns involved.

Following this discussion the delegates adjourned to the moving picture theatre to witness two films on physiotherapy and occupational therapy presented by Dr. Chris. M. Sampson of the United States Public Health Service.

Dr. Harold W. Hersey presented the report of the committee on general furnishings and supplies, with the recommendation that the standardization of such equipment be carried to the greatest practical degree. His committee discussed tendencies and the more recent practices in the selection of beds, metal and wooden furniture, mattresses, pillows, casters and linens. No opposition developed to any of the recommendations of the committee and President O'Hanlon's call for discussion brought no delegate to his feet. The report is printed in full on page 334.

Dispensary Section Lively

Interest never waned at the section on dispensaries Tuesday afternoon. Mr. John E. Ransom, superintendent of the Michael Reese Dispensary, Chicago, occupied the chair and announced as the major topic for Discussion, "The Educational Value of the Out-Patient Department." Dr. John M. Dodson, dean of Rush Medical College, Chicago, in a forceful paper considered the theme from the standpoint of the medical student, intern and practitioner of medicine. In the absence of Dr. Haven Emerson, professor of hygiene and public health at Columbia University, New York, the chairman read his treatment of the topic from the angle of the patient and the community.

The dispensary's value in modern medical education is given high value by Dean Dodson who considers the out-patient department the best place for medical instruction because: (1) the student can get the clinical history of the ambulant patient more easily than he can that of the hospital patient; (2) the dispensary patient can be more readily and more extensively examined; (3) the student meets the patient in the incipiency of his illness and therefore can learn methods of prevention; (4) he is able to absorb technique of the social worker in ascertaining the family condition; and (5) he may see the convergence of many specialized lines of treatment.

From the standpoint of the practitioner the dispensary offers superb material for true graduate study; to a limited number of doctors it offers opportunities for specialization; and most important, in Dean Dodson's opinion, it is a place for the family practitioner to "brush up."

"We are facing a serious dearth of interns," said Dean

Dodson. "Medical schools cannot turn out enough students to supply the demands of hospitals for interns without flooding the country with physicians. The solution to this problem, I believe, is in resident intern service from practitioners in the vicinity."

The Family Doctor as Intern

"The family doctor could come into the hospital for from three to six months to the great benefit of his own practice and to the immense service of the hospital to its community. With good literature and laboratory facilities there is not a hospital of 100 beds in the country that cannot become a teaching hospital."

Some defects of present dispensary arrangements as Dean Dodson views them he enumerated as follows:

(1) The practice of assigning the duty of distributing dispensary patients to a non-medical person. All cases first should be referred to a doctor of general medicine for a complete examination. He should refer the case to a specialist only when it requires expert attention. Group practice of specialists can be thoroughly vicious unless there is some one to see that the patient gets a general examination first.

(2) There are some grounds for the contention regarding the exclusion from the dispensary of those that can afford to pay. Such practices tend to pauperize the community.

(3) The failure to use the out-patient department for teaching the general practitioner.

(4) The unfair arrangement of the work of medical students. The dispensary offers advantages in general medicine for both the beginner and the advanced student, and the junior student gets his best training in clinical records for the dispensary.

(5) Contrary to present practice, the dispensary is the place of all others to teach preventive medicine. Medical practice of the future lies largely in this field. The physician must be not only the family doctor but the family health adviser. The dispensary offers the physician a source of income which he needs, but he has hitherto given his services gratis. If the medical profession does not take up preventive work, somebody else will for the public is coming to demand it.

(6) There will be no effective public health service unless physicians intelligently cooperate with the public health officers. This entails a complete change of attitude on the part of the teachers of clinical medicine to get the social and public health viewpoint of each case.

In the discussion which followed the paper, a representative of Jersey City Hospital said that the out-patient department in his belief is apt to be rather careless about the selection of its staff. Michael M. Davis, Jr., of the Committee on Dispensary Development, New York, sketched the activities of the Cornell pay clinic. It was the opinion of Dr. Castleman of New Jersey that the staffs of small town hospitals are not equipped to teach the practitioners, being not so far advanced as their city brothers. Dean Dodson attributed this fact to the lack of stimulus to progress among country doctors because they did no teaching. Richard P. Borden, trustee of Union Hospital, Fall River, Mass., lamented the physicians' neglect of the great field for observation and education which the dispensary affords. That specialists would not care to accept the diagnoses of general medical men in group practice was the opinion of Dr. May of Washington, D. C.

Stage Set for Health Teaching

Dr. Emerson's paper in discussing the educational value of the dispensary to the patient and community read in part:

"We doctors, nurses, administrators and social workers are so intent upon our own professional job at the dispensary that we forget that what we are about is some kind of doctoring, and that doctoring is a good Latin equivalent for teaching. All the ingredients are ready at hand,—the person, or even better the persons, groups of them bound together by common interest in the most democratic of all things, disease; the state of mind essential for learning, created by desire to avoid further suffering or hope of return to health; a trustfulness and faith in the teachers that is one of the elements of pedagogic inspiration; the place; the time; and what is more important than anything except the pupil, something urgent to be taught, a matter of life and death, a matter of pain or blissful sleep, a problem of salvaging a family or losing the home.

"The dispensary as a place of public assembly where the audience selects for itself particular objectives might, in a most elementary form, offer instruction by printed word and painted lesson, by raising a smile or rousing curiosity, while the waiting sufferers sit fac-

The Child Health Railroad in the exhibit of the Atlantic County Committee of the New Jersey Tuberculosis League attracted many interested visitors.

Interesting statistical material on hospital service was furnished delegates at the booth of the Hospital Information Bureau of the United Hospital Fund of New York.

Father C. B. Moulinier, the guiding spirit of the Catholic Hospital Association, was active at Atlantic City.

ing the wall. In its logical suitable development, this simple teaching by bill poster or advertising sign could be expanded to include a beguiling entertainer whose business it will be to pick up the patient on admission and keep him or her, young or old, thinking and asking questions up to the moment of escape into the examining or treatment room."

Dietetic Section of Value

Two worth-while papers and an unanticipated report made up an eminently worth while session of dietitians on Tuesday afternoon. Miss Lulu G. Graves, supervising dietitian at Mount Sinai Hospital, New York, presided over the section on dietetics.

To the benefit of the dietitians but to the dismay of the general convention attendants, the report on food and food equipment, prepared by one of the exposition committees, was read at this section. No previous announcement of this change of program was made, so that many superintendents who wished to hear the report were denied that privilege. Dr. C. W. Munger of the Blodgett Memorial Hospital, chairman of the committee, presented the report, an abstract of which will be found on page 329 of this issue.

In the opening paper at this section Dr. Frank Howard Richardson, children's department, Brooklyn Hospital, Brooklyn, N. Y. dealt in detail with the subject of the relation of the hospital to children, putting forward suggestions for solving the problems of this aspect of the hospital. He laid emphasis on the desirability of reducing the time spent by the child in the hospital and treated also the subject of his proper feeding while there.

Children's hospitals, said Dr. Richardson, have yet to justify their existence; they are still on trial. Startling statistics, gathered from institutions for the care of children, show there a heavy mortality rate among children who stay for any length of time. The pros and cons for the hospital care of children are pretty evenly balanced but the appalling death rate noticeable in even the best regulated infant's wards, the danger of cross infection, the hardship of separation felt by both parents and children and the undesirable mental effect upon the child of the sights and sounds of a hospital, these and other drawbacks present a real problem. The way out seems to be the out-patient pediatric department, and this agency, with its logical appendage, the nutrition and health class, should be utilized to its fullest extent, and can be developed in many directions.

With regard to the feeding of infants Dr. Richardson feels there has of late been healthy reaction from the old time elaborate milk formulas to what are known as "simple dilutions." The extreme importance of the care of milk, this product so highly perishable and so easily contaminated, has come to be widely realized. The only milk fit to be given to an infant or a child is pure, fresh unaltered cow's milk and the only milk that conforms to these simple and minimum requirements in our cities is certified milk.

In her paper, entitled "The Relation of the Department of Dietetics to the Hospital Composite," Miss Marion Peterson, supervisor of administration in the department of dietetics, Lakeside Hospital, Cleveland, suggested a variety of ways in which the department of dietetics may contribute its share toward the general usefulness of the hospital, and dwelt on the interdependency of the different departments of the hospital.

Variety the Dietitian's Watchword

The dietition's responsibility for the three meals a day, said Miss Peterson, gives her a unique point of contact with every individual in the hospital and therein lies her great opportunity. In planning meals variety should be the dietitian's watchword, for institutional food so readily becomes monotonous, and she should ever remember the special needs of doctors and nurses detained late in operating room or ward and see that their food is hot and freshly prepared and does not consist of cold leftovers. By serving meals that satisfy she can aid

Two of the convention's busiest men were Dr. S. S. Goldwater and Dr. Otho F. Ball.

largely in preventing food waste. Dietitians should have opportunity to visit patients and thus learn their preferences and customs so that she may plan for them intelligently. Let her give the Italian spaghetti once in a while, the Scandinavian pickled herring, and win a contented patient and a friend for the hospital.

Miss Peterson pointed out that the dietitian should be a teacher as well as a provider; instruction should be given to the patient prior to his leaving the hospital and visits paid to his home afterwards to help there during the difficult period of readjustment. Recipes should be given out and guidance offered in the use of certain foods. Dietary supervision, supplementing medical care, may prevent in many cases the need of hospitalization and should be continued indefinitely. Work of this kind makes possible close cooperation between the dietitian and the social service worker and will be mutually beneficial.

The educational work of the dietitian extends beyond the instruction given to patients, for the teaching of pupil nurses holds an important place in her work. Doctors increasingly realize the soundness of dietotherapy and demand more and more knowledge of this subject from their nurses. Intensive dietetic training for pupil nurses will be possible of course only where there is a full time instructor in the diet kitchen. In some hospitals the interns also are given instruction in practical dietetics to supplement the theoretical knowledge they receive during their training. There are also the student dietitians who must depend so much upon what they can derive from their course of apprenticeship. The department of dietetics should be maintained with the finest possible organization in order that these students may receive the right sort of background.

Fears Excess in Standardization

Dr. George D. Stewart, president of the New York Academy of Medicine, in an entertaining address opened the general session on Tuesday evening. His subject was "Standardization Values" and he sounded early warning that he did not set too high an estimate on that practice which has lately become the cry of the hour.

"Nowadays," began Dr. Stewart, "we standardize everything from ship building and hospital administration to birth control and control of appetites. Standardization is largely begotten of our economic necessities and sometimes it leaves out all other considerations. It is a recognition of the fact that we have exploited our natural resources and if carried to excess hinders progress.

"The standardization of medicine and of hospital management may result in much good or in great danger. The easiest way to settle down into a rut is to standardize. I have even heard of one hospital superintendent who issued typewritten directions for its staff members to follow in performing an operation. I deplore the attempt to make me do a thing a given way, if I can do it a better way.

"Standardized histories in the hospital can constitute a source of great error, if made by one man and filled in by another. In my opinion the histories should be made by the man himself and interpreted by him. Collectivism and standardization lead toward communism and in communism individuality is relinquished entirely."

Dr. O'Hanlon (right), retiring president; H. E. Webster (center), a former vice-president; and an exhibitor.

Dr. and Mrs. Stephens strolling down the Boardwalk, with a Canadian confrere, Dr. Haywood.

Recommends Mutual Liability Insurance

One of the most worthwhile papers of the convention was that of Mr. John A. Lapp of the National Catholic Welfare Council on "The Liability of the Hospital." Mr. Lapp, a graduate in law and a close student of hospital and health problems, has during the past year made a comprehensive survey of recent legislation affecting the liability of hospitals.

"The hospital should not get alarmed about its legal liability," Mr. Lapp asserted after citing several cases in which high courts had fixed responsibility upon hospitals. "The liability of a properly run hospital is very slight. Liability may force upon trustees and managers greater attention to the trust which has been imposed upon them, but if their duties are properly performed there is slight cause for fear. On the other hand, a hospital which is not properly run, a hospital which has a reputation for slovenly work and unsanitary conditions, may well look to its liability."

Mr. Lapp was of the opinion that charitable hospitals should insure against liability but not at exorbitant rates. Since liability is slight in the average well-managed hospital, rates of insurance should be extremely low. He suggested that a hospital mutual insurance company operated at cost by the hospitals themselves would be a satisfactory way to handle that situation.

Before the program was concluded, President O'Hanlon called upon Bird S. Coler, commissioner of public welfare of the city of New York, for some impromptu remarks. The commissioner told something of New York's hope to become the world's center of medical

teaching, and something of its present hospital facilities which he characterized as entirely adequate.

Trustees Hold First Meeting

Wednesday morning was signalized by the first meeting of the association's section on trustees, of which Mr. Arthur A. Fleisher, president of the Jewish Hospital of Philadelphia, was chairman and Mr. Henry C. Wright of New York secretary.

The meeting was opened by Dr. O'Hanlon, president of the association, who asserted that this section should have been one of the first sections of the association, inasmuch as trustees should know about the hospital in all its aspects.

The section did not have a set program, but devoted the morning to an informal discussion of a number of suggestive topics. The first topic was the kind of reports which superintendents should make to their boards of trustees. One delegate thought the report should cover: (1) The financial condition of the institution, showing its general expenses and the per diem cost per patient; (2) the activities of the different departments and (3) the needs of the hospital, pointing out the defects and making such suggestions as will enable the board of trustees to act intelligently.

Mr. Henry C. Wright of New York pointed out that the kind of report made by the superintendent will depend to some extent on what the trustees regard as their functions. If certain of these functions are delegated to committees they should report directly to the board.

Mr. W. W. Rawson, superintendent of Thomas D. Dee Memorial Hospital, Ogden, Utah, felt that committees of the board of trustees should discuss their action with the superintendent of the hospital and let him incorporate their views in his report. In this view Mr. Rawson was supported by Mr. Daniel D. Test, superintendent of the Pennsylvania Hospital of Philadelphia.

Mr. Henry C. Wright pointed out that two things that often cause great trouble in the hospitals are the incompetency of the superintendent and the interference by members of the board of trustees in administering the details of the hospital; he made a plea for the assignment of particular zones of action and function to both superintendent and trustee.

President and secretary of the newly created section on trustees, Mr. Arthur Fleischer (right) and Henry C. Wright (left).

Mr. Richard P. Borden Union Hospital, Fall River, Mass. stated that since the hospital exists primarily for the benefit of the patient, the superintendent should report to the board of trustees all action taken by the hospital regarding patients. No single trustee in his opinion should act as an intermediary between the board as a whole and the hospital. This should be the function of the superintendent. Special committees of the board should always act in consultation with the superintendent. Committees may investigate special subjects, but usually cannot do so successfully without using the knowledge which the superintendent has on the question.

Mr. Frank E. Brooke, superintendent of the Harrisburg Hospital of Harrisburg, Pa., stated that his board of trustees, has a system of functioning committees, consisting of a finance committee, a medical committee, a supply committee and a property committee. These committees meet previous to the monthly meeting of the board, and the superintendent sits at each of these committees and at the meeting of the full board. The superintendent conducts the meetings of the committees, who are required to thresh out details and present written reports at the regular monthly meetings of the entire board. In this way the plans and ideas of the superintendent are presented to the board through its committees.

Mr. Thomas Zulick, superintendent of the Paterson Hospital, Paterson, N. J., said that in his institution the superintendent reports the financial and other conditions of the hospital, the work of the staff and whatever actions may be taken at the staff meetings.

Discussing the question of how trustees can best keep in touch with the work of the institution, Mr. Rawson of Ogden, Utah, pointed out that in his institution they have an advisory committee of physicians which meets with the committee of trustees and the superintendent once a month. There is also a meeting of the trustees on nursing, which meets once a month with the nurses.

Mr. Henry C. Wright described the plan which the trustees of Bellevue Hospital recently adopted for expediting its business and an agenda of each meeting of the trustees is mailed to reach the trustees two days in advance. After the superintendent submits his report, the chairman of the board asks the trustees present whether they desire to reserve any of the items of the agenda for discussion; those not reserved are then passed upon as a whole with the recommendation of the superintendent.

Satisfied Patients Best Publicity

The second question related to the kind of publicity hospitals should undertake. Mr. E. S. Gilmore of Wesley Memorial Hospital, Chicago, felt that the best publicity was a well treated patient. For special purposes, such as raising funds for a new building, he recommended the employing of a publicity expert.

Mr. Brooke of Harrisburg, said when he first went to that city he invited the editors of local newspapers, together with the reporters assigned to the hospitals, to meet him personally. Through this personal contact he has been able to secure the kind of publicity he desires.

Dr. Charles E. Ide, superintendent of Muirdale Sanatorium, Wauwatosa, Wis., described an interesting experiment under which the newspapers were given an idea of the hospital and its work through a committee of patients.

Speaking of the question of how the public should be appealed to for funds, Mr. Borden of Fall River, Mass., held that this was a difficult problem and it was not possible to establish any definite way that would be adaptable to all communities.

A further question discussed was what constitutes hospital policy. Discussing this subject, Mr. Wright stated that trustees must do two things, they must determine policies and hold themselves to them; and also determine

SOME RIDE AND SOME STRIDE AT THE FAMOUS OCEAN RESORT

what reports mean. Policy must be distinguished from procedure.

Protest Collateral Inheritance Tax

Discussing the question of whether hospitals under private management should receive state funds, Mr. Charles Ford, director of the activities of New York State Board of Charities, stated that some time ago New York abandoned state aid and adopted the policy of local aid. The hospital charge becomes a matter of agreement between the locality and the hospital in that locality. The amount paid by the locality is generally higher than the hospital could expect from the state and in many instances it approximates the cost of maintenance.

Mr. Borden of Fall River urged that trustees should now further the work of the American Hospital Association by becoming institutional members and thus providing the Association with necessary funds.

The session closed with the adoption of the following resolution: Resolved, That the division of portions of legacies to hospitals, homes or other charitable or religious organizations for state purposes, through the means of a collateral inheritance tax or in any other manner is such a harmful and detrimental procedure, that the trustees section of the American Hospital Association desires to place itself upon record as being opposed to any such method of taxation.

Nursing Section Is Profitable

Wednesday's program yielded a succession of reports far-reaching in their scope and in their future. At the morning section on nursing was discussed with intelligent criticism the report on nursing education, that forward-looking document prepared under the auspices of the Rockefeller Foundation. The section on administration in the afternoon centered its program around the report on the training of hospital executives. In the evening before the social service section, Mr. Michael M. Davis, Jr., presented the findings of his committee on training for hospital social work.

Miss Amy R. Hilliard, R.N., superintendent of Samaritan Hospital, Troy, N. Y., opened up the discussion of the nursing education report, as the section was called to order by its chairman, Miss Laura R. Logan, superintendent of nurses at Cincinnati General Hospital.

To the report's conclusions regarding additional training for public health nurses, Miss Hilliard thought all nurses would subscribe. She called attention to the "sham courses" in public health nursing being conducted in Chicago by a former commissioner of health and declared that it passes understanding that any hospital would employ one of these workers.

"The scope of nursing schools must broaden to the level of other schools of higher education," said Miss Hilliard. "For such an exacting professional career the background should equal those of colleges. We must lend our efforts to obtain the endowment of schools of nursing. The public is so accustomed to consider the nurse as an obedient servant that it does not see her as a financial obligation. Further we must see to it that administrators and supervisors of nursing schools are not recruited from the inexperienced and unprepared. They must have the definite educational preparation required for executives in any other professional school. And we must all work toward national standards for licensure of persons of any grade who have as their profession the care of the sick."

Chief interest among nurses today undoubtedly centers about ward helpers or attendants. Miss S. Lillian Clayton, R.N., director of nursing at Philadelphia General Hosptial, in presenting an able paper on "The Use of Ward Helpers," opened up this fertile field of discussion.

Attendants of Real But Limited Value

Miss Clayton defines ward maids as those persons employed in the hospital for housekeeping purposes who have had no previous training or answer no educational requirements. Ward helpers, according to her classification, are persons of greater intelligence but possessing no educational standards beyond the ability to speak and write English. They are workers, not learners, and their position is in no way to be considered as experience in the care of sick. Ward attendants, as she defines them, are grammar school graduates to whom the hospital furnishes maintenance, uniforms and a small allowance, and to whom is given careful preparatory training of eight or nine months at the end of which they receive a certificate.

In introducing any of these groups in the hospital, that institution should first be satisfied that it can train them without exploitation, Miss Clayton asserts. Any hospital should refuse to conduct such a course unless the training can be given in perfect fairness to the workers, the public and the hospital.

Four recommendations were made by Miss Clayton regarding attendants: (1) The hospital should not employ more than are needed for actual work; (2) The patient should not be subjected to their care when critically ill; (3) the hospital should have as satisfactory a reputation for its attendants' schools as for its school of nursing; and (4) the hospital should refuse to train attendants until legislation makes it impossible for physicians and the public to employ them as full grade nurses.

"There is no question as to the attendant's value," said Miss Clayton, "but her value is limited. The American Hospital Association and the nursing organizations should unite their efforts until this present problem of the attendant is worked out satisfactorily."

THE MODERN HOSPITAL booth served as a general information office and conference room for delegates, as well as fulfilling its educational and promotional functions.

A spirited discussion of the report and of Miss Clayton's paper followed.

Miss Mary A. McMillan, superintendent of the School of Nursing at Presbyterian Hospital, Chicago, believes that the twenty-eight month course recommended in the report is too short in most instances. She suggested

that some hospitals give that length of course but that others be allowed to continue the full three years of work so that the student could select the course she desired.

That the twenty-eight month course is an experiment well worth trying is the opinion expressed by Miss Elizabeth A. Greener, director of nurses at Mount Sinai Hospital, New York. The purpose of the shortened course is to relieve the student from unnecessary, non-professional duties, said Miss Greener, and many of these can well be spared.

Miss Elsie M. Lawler of Johns Hopkins Hospital, Baltimore, believes that twenty-eight months are not sufficient for training unless the course is properly safeguarded.

The duty of nurses, as seen by Miss Jane M. Pindell of Franklin Square Hospital, Baltimore, is to arouse public sentiment toward the appropriation of funds for additional high school facilities so that nursing students may meet the higher requirement for admission.

Miss Minnie Goodnow of Children's Hospital, Washington, D. C. cited figures to show that one out of every six graduates of high schools must enter nursing training schools if the demand is to be met. The only way to provide sufficient care for the sick lies in the training of a group of attendants, she believes.

Nursing students and nursing attendants should not be trained in the same hospital in the opinion of Miss Rose Van Wort, superintendent of the Stuart Circle Hospital, Richmond, Va. She related to the convention some details of the Virginia plan of training attendants, which includes the provision of a patented separate uniform for nursing attendants to prevent them representing themselves as graduates of regular training schools.

There was always a crowd of information seekers at the exhibit of the Hospital Library and Service Bureau.

Superintendent Steffen of a Columbus (Ohio) hospital, declared that attendants will represent themselves as graduates and nothing can be done to prevent it. He would be most reluctant, he said, to give courses for the two grades of nurses in the same school. A superintendent of a small hospital, Miss Burns, contributed to the discussion by saying that the small hospital is no place to give a short course.

Dr. Ernst P. Boas, head of Montefiore Hospital for Chronic Diseases, New York, agreed that it was impossible to control the graduates of short courses after they leave the institution. In spite of legislation in his state, he declared, short-term nurses are now practicing as full-term graduates. In a large city the best type of woman is not attracted by the short courses, in his judgment.

The nursing section contributed to the convention one of its strongest papers in Miss Annie W. Goodrich's presentation of the role of the hospital in the community health program. Miss Goodrich is director of nursing at Henry Street Settlement, New York.

"The hospital's duty," Miss Goodrich explained, "is to function either as a health center in a given area or as a link in health activities. To bring this about means the reconstruction of the entire hospital program, method and system. The hospital must figure in preventive rather than curative medicine.

"The unit of hospital responsibility in the new program will be the family, not the patient. The hospital must assume its obligation to the public and to its own personnel. It is necessary that the intern be provided with recreation and a healthful routine, for long hours and overwork on his part will react disastrously on the patient. In cooperation with health and social agencies the hospital is agonizingly slow and intolerably aloof, but the tendency is growing."

Gauze Reclamation a Success

Dr. A. B. Denison's report on the renovation of gauze and standard dressings took up the early afternoon hours on Wednesday. The committee's method and findings are contained in an abstract of the report on page 328 of this issue.

Massachusetts General Hospital was the first institution to inaugurate the practice of washing gauze, and Dr. Frederic A. Washburn recalled its early efforts in that direction in the discussion which followed the report. This institution tested the life of the gauze on one occasion by running a black thread through any given piece each time it was washed. Some of the pieces were washed as many as twelve or thirteen times, it was learned.

Daniel D. Test, superintendent of Philadelphia General Hospital, another pioneer in reclaiming gauze declared that $90,000 has been saved his institution by that means. The necessary apparatus for its reclamation cost $750.

Rappleye Reviews Report

The section on administration concerned itself almost wholly with the recently completed report of the committee on the training of hospital executives. Dr. Willard C. Rappleye, executive secretary of the committee, himself was on hand to present the report. The convention later approved it, after full and free discussion had been engaged in.

In reviewing the report, Dr. Rappleye commented upon the growing philosophy of community responsibility which hospital executives are developing. The hospital occupies a strategic position in the field of health, he declared, the common ground about which can be mobilized the various agencies of health promotion. For this enlarged responsibility is needed an executive of a broad vision of service. It is this type of administrative officer which the suggested course of study hopes to turn out.

Dr. Rappleye's committee views as preliminary requirements for the course suggested maturity, education and an indication of executive ability.

Congratulations were offered the committee by Dr. Winford H. Smith, superintendent of John Hopkins Hospital, on its definition of the future hospital function. The difficulty in its realization, as he sees it, is in at-

tracting the right type of persons into the work. To get proper executive material, he thinks, there must be a broadened field of usefulness and in the way of this broadened field stands: (1) the acute opposition of the medical profession to view community medical problems through organizations rather than individuals; (2) the lack of interest on the part of medical men in executive work as a career; (3) the difficulty in getting men and women to enter such a training course.

"We won't get men and women to take up this training course," he declared, "until we get a recognition

The American Library Association arranged an attractive booth in Exposition Hall with a suggestive exhibit of a hospital library. Scenes in the libraries of army, navy and public health service hospitals decorated with walls, and posters and charts showed graphically the extent and possibilities of library service in institutions which house and care for the sick.

from the medical profession, hospital boards of trustees and the community that it is a career of essential value to the working out of the health problems of the community. To offer a course in administration at present will not yield the type of men we want. Our best hope in this connection would be the inauguration of the course in an institution where there exists a well organized school of public health."

Must Catch Them Young, Says Washburn

Quite of another opinion was Dr. Washburn of the Massachusetts General Hospital.

"It isn't necessary to broaden the field," he brought out, "but the difficulty in getting the right class of men lies in the fact that we don't catch them young enough. If medical schools would place emphasis on hospital administration as a career, the problem would be more readily solved."

Dr. Washburn expressed his personal approval of the report and said in his judgment it possesses sufficient force to induce some university or foundation to take it up.

To Dr. Rappleye's trio of requirements for entering the course, Mr. Test of Philadelphia General Hospital, would add another three: character, temperament and "horse-sense." Mr. Test asserted that the committee has made an excellent start and the convention should get behind the report.

Dean John M. Dodson of Rush Medical College, Chicago, contributed the opinion that if hospital executives are properly trained, officials will make the career attractive, financially and otherwise. He suggested that at first some fellowships should be offered as special inducements to enter the course.

"Medical schools in the past have been neglectful in emphasizing the possibilities in administration," Dean Dodson stated. "They must face a complete reorganization: (1) to emphasize the preventive side of medicine in which the hospital is a health center; and (2) to have regard for other avenues of activity than that of the practitioner, among them the hospital superintendent."

John R. Howard of the New York Nursery and Child's Hospital entered the discussion by declaring the report 100 years ahead of the times. It will be necessary to educate hospital trustees as well as hospital executives to this new vision of the hospital's function, he added. To run a hospital and to organize a community health service takes two entirely different types of mind, in Mr. Howard's opinion, and he thinks the report expects the impossible. He further criticized the suggested curriculum on the grounds that it will not train a man as an executive of a metropolitan hospital.

Edwin R. Embree, secretary of the Rockefeller foundation, was present at the session and in a brief talk sketched hospital conditions in the Orient from which he recently has returned. The whole background of health appreciation in the Orient has been laid by the hospitals, he declared. It was the mission hospital which first led the Chinese to appreciate the importance of means of controlling disease.

Hospital Social Workers' Section

Wednesday evening's program, following the transaction of a small amount of general business, was largely devoted to the section on social service of which Miss M. Antoinette Cannon was a most gracious chairman.

William H. Matthews, director of the Family Welfare Association for Improving the Condition of the Poor in New York, opened the section program with an address on "What Social Service in its Hospitals Means to a Community."

"Sickness is the chief recruiting sergeant for relief agencies," said Mr. Matthews, "and the hospital social service worker can be a positive constructive factor in the institution. The hospital and dispensary cannot give the best kind of service to their patients when they have to be rushed through subway-turnstile fashion. Here lies the province of the social worker—to take the patient immediately following the physician's pronouncement of his ill and reassure him that his family and himself need not suffer during his treatment and convalescence." Mr. Matthews cited several situations where the social worker was the saviour of morale and the essential factor in rehabilitation.

Dr. Charles A. Drew, medical superintendent at Worcester City Hospital, takes a stroll.

The thorough and significant report of the committee on the training of hospital executives, just

completed, was then presented to the convention in abridged form by its chairman, Michael M. Davis Jr. The report was enthusiastically received and warmly commented upon in subsequent discussion. An abstract of it in some comprehensiveness will be found on page 322 of this issue.

John L. Montgomery, executive secretary of the Monmouth County (N. J.) Organization of Social Service, sketched some of the many services that association furnishes a mixed urban and rural community. Travelling mental hygiene clinics, travelling dental clinics for rural school children, county appropriations for the poor, demonstration psychiatric clinics in the hospitals and numerous other constructive health measures are being carried on by this organization in cooperation with Monmouth Memorial and Ann May Memorial Hospitals and the county sanitorium. The schools and hospitals are in close cooperation in providing these services.

Another interesting accomplishment in the field was described by Miss Mary Tobin, director of social work at the Neurological Institute in New York. It is social work with problem children and has already a splendid showing in assisting children of from two to eighteen years in making social adaptations. Not less important than the work with children is the concurrent education of parents. A successful phase of the work is the practice of taking all social histories in the children's homes. Then when the psychiatrist first sees the child, he has all the information regarding environment and general home conditions.

Experiences with the uneducated "mountain whites" of Kentucky in health and social work were related by Miss Annette Cowles, superintendent of Children's Free Hospital at Louisville in a short address. Miss Cowles stressed the need of social service and public health workers throughout the South and showed how her own small hospital has been a factor in teaching personal hygiene to the children and mothers of a degraded class.

No warmer praise of hospital social service work was spoken during the evening than that contributed by Oliver H. Bartine, hospital consultant of New York. Mr. Bartine stressed the importance of locating the social service department in hospital planning. The offices of this department should be centrally situated and in close proximity to the administrative offices. Desk room for the social service workers can then be provided in the outpatient department, but the social work of the entire hospital will be centralized.

The general session on Thursday morning was devoted to the report of the exposition committee on laundry equipment and supplies, which was read by its chairman, Dr. William P. Morrill, superintendent of Shreveport Charity Hospital, Shreveport, La., and to a paper by Dr. Willard C. Stoner of St. Luke's Hospital, Cleveland, Ohio, on the hospital problem in relation to modern medicine. This paper was originally read at the last meeting of the Methodist Hospitals and Homes Association and will be found in abstract in the March issue of THE MODERN HOSPITAL. There was no discussion of either paper.

The convention at its closing business session made three amendments to the constitution. One raises the dues of associate personal members from $2 to $3 a year. The second reads that "active personal members shall be those who at the time of their election are trustees or superintendents or assistant superintendents of hospitals, or members of medical staffs of hospitals, or executive officers of any organization having as its primary purpose the development of hospitals for general public service, the scope and nature of whose work is approved by the board of trustees. Any person once an active personal member may continue such membership as long as the rules of the association are conformed with." The third amendment increases the personnel of the membership committee from three to five members so that all natural Geographical Sections may be represented.

Edwin R. Embree, secretary of the Rockefeller Foundation, which gives ample evidence of its interest in the betterment of hospital service.

Mr. Richard P. Borden, chairman of the resolutions committee, moved that since many of the resolutions presented bore on questions of policy, not to be entered upon hurriedly, all consideration of them be postponed until the next annual conference. His motion was carried.

Announcement of the election results brought renewed interest in the theater. The only closely contested office was that of president for which Dr. Willis G. Neally of Brooklyn Hospital received 125 votes and Dr. Malcolm T. MacEachern of Vancouver General Hospital received 181.

Prolonged applause greeted Mr. Asa S. Bacon, the new president, as he took the chair and in a straightforward and sincere address pledged himself to his task. His speech of acceptance is printed in full on page 272 of this issue.

Mr. Bacon had his committee appointments already drawn up and these were read preceding adjournment.

They are as follows:

Committee on Constitution and Rules

Richard P. Borden, trustee, Union Hospital Fall River, Mass.; George S. Hoff, secretary, Lake View Hospital, Danville, Ill.; John M. Peters, M.D., superintendent, Rhode Island Hospital, Providence, R. I.

Committee on Nomination

George F. Stephens, superintendent, General Hospital, Winnipeg, Canada.

Charles S. Woods, M.D., Indianapolis, Ind.

W. P. Morrill, M.D., superintendent, Shreveport Charity Hospital, Shreveport, La.

Lewis A. Sexton, M.D., superintendent, Hartford Hospital, Hartford, Conn.

C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.

Committee on Membership

The Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis.; Miss Margaret Cummings, superintendent, Buhl Hospital, Sharon, Pa.; Sister Geraldine, St. Elizabeth's Hospital, Youngstown, Ohio.

Committee on Out-Patient Work

Alec N. Thompson, M.D., director, Department of Medical Activities, American Social Hygiene Association, New York.

A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Canada.

Walter Niles, M.D., dean, Cornell Medical College, Ithaca, N. Y.

BETWEEN SESSIONS DELEGATES PROMENADED ON BOARD WALK AND PIER

WIDE INTEREST IN ROUND TABLE SESSION

DELEGATES gradually have come to look to the round table as furnishing the real meat of the annual conference. This year their anticipation was proved not too high, for Mr. Asa S. Bacon, the King Arthur of hospital round tables, led a most varied and profitable discussion.

Acceleration of the general program, brought about by the desire of many in attendance to leave on evening trains crowded the general business session forward into the round table meeting and somewhat curtailed its scheduled program. A number of questions sent in were thus unanswered, but they with the replies will be included in the annual convention report, Mr. Bacon announced.

QUESTION 1. What percentage of the hospitals in the association allow osteopaths to care for patients in the hospital; and under what conditions, if any, are they allowed?

Dr. W. P. Morrill, Shreveport (Ala.) Hospital: By the questionnaire method the following figures were obtained in relation to the percentage of hospitals which allow osteopaths to care for their patients: 83⅓ per cent do not admit them; 11⅓ per cent admit them under the supervision of M.D.'s; three per cent permit them to practice independently.

Some extremely amusing and illuminating comments accompanying the questionnaire replies were read by Dr. Morrill. One institution admits osteopaths if the patient will sign a paper assuming full responsibility; another admits but "does not encourage" them; one writes, "They shall not pass."

QUESTION 2. (a) Where a nurse is trained in the giving of anesthetics and a death results directly from anesthesia, who is held legally responsible for this? (b) Can an institution chartered as "charitable, not for profit" be sued for such a mishap?

Dr. E. T. Olson, Englewood Hospital, Chicago: (a) As an employe of the hospital or the doctor, the nurse is an agent and they are responsible. Proven neglect of permission or omission of doctor or hospital would render either of them liable. If the anesthetist is working for a fee, she is subservient to the doctor. If ordinary care, skill and judgment are observed by the hospital or doctor, no judgment should be rendered the plaintiff.

(b) Any hospital or individual may be sued. Supreme courts of some states have held that no damages may be collected from charitable institutions on the grounds that it is an improper diversion of funds held in trust for other purposes. Other states differ.

Mr. Daniel D. Test, Philadelphia General Hospital: If all reasonable precautions are taken, recovery cannot be made, but any decision will be rendered on the merits of the case.

QUESTION 3. Should any other, except physicians, give anesthetics; for example, nurses?

Dr. Malcolm T. MacEachern, Vancouver (B. C.) General Hospital: The question of nurses giving anesthetics is a controversial subject and is dependent upon four factors: its medico-legal aspect, economy of service; efficiency of the anesthetic; and consideration of the patient. The best practice is to have a department of anesthesia with a medical man at the head and with the nurse as his technical assistant.

QUESTION 4. What is the duty of those in charge of the hospital when the patient under the care of an unethical doctor asks to be admitted to the hospital?

Dr. C. B. Hildreth, St. Luke's Hospital, Cleveland: The American College of Surgeons clearly defines it as the duty of those in charge to pass on information to the patient.

QUESTION 5. Is it advisable to have medical protective insurance for hospitals?

Mr. E. S. Gilmore, Wesley Memorial Hospital, Chicago: Any hospital is foolish if it does not have such insurance. Since it is the patient who creates the need for such protection, the expense should be defrayed by him. The insurance should be added to overhead, and the rates so adjusted as to cover it.

QUESTION 6. (a) Should the hospital staff be under the control of a chief, or president and executive committee?

(b) How many doctors ordinarily comprise a good staff; or, in other words, how many should be on the staff of a 250-bed hospital with an out-patient department?

(c) Should doctors who are active in the hospital proper (as staff members) also be on service in the out-patient department?

Dr. C. W. Munger, Blodgett Memorial Hospital, Grand Rapids, Mich.: (a) No hospital should be under the control of any one man. Every staff should have a presiding officer elected by the staff and approved by the trustees. Some times it is wise in a newly organized hospital to have the chief appointed by the trustees, but this should not be adopted as a policy.

(b) Although it is impossible to generalize, a study of a number of hospitals averaging 250 beds shows that there is one doctor for every five patients where charity work constitutes 30 per cent of the hospital practice.

(c) In my opinion the doctors who are active in the hospital proper should not also be on service in the out-patient department because these men have large private practices are too busy, and further because the younger men need the experience. The more mature doctors should be utilized as consultants.

QUESTION 7. In a small city of 10,000 inhabitants with a forty-bed hospital where all the doctors send their patients for treatment, what form of staff organization is most ideal?

The Rev. H. L. Fritschel, Milwaukee (Wis.) Hospital: All physicians in the community should form the staff with an executive committee to govern.

Exception to this answer was taken by Mr. Golden of West Virginia who said in his experience in a town of 10,000 better results are obtained by a staff appointed by the board of trustees.

QUESTION 8. What is the proper attitude toward allowing visitors in the operating room during operations?

Mr. Paul H. Fesler, University Hospital, Oklahoma City, Okla.: Visitors should not be permitted in the operating room. In charity or clinical cases, this rule is more easily enforced, but with private cases it sometimes is necessary to use great effort.

Dr. E. T. Olson of Chicago said that no distinction is made in Chicago and that no lay visitors are permitted in the operating room during operations under any consideration.

QUESTION 9. Should the association make the daily programs longer or shorter?

Dr. Raymond G. Laub, Greenpoint Hospital, Brooklyn,

Wide attention was attracted by the educational panels worked out by the National Child Welfare Association on the various health phases of normal childhood.

N. Y.: It seems to be the consensus of opinion that the length of the night sessions should be reduced. Exhibitors say that they want the sessions to start promptly and to finish when it is announced they will.

QUESTION 10. Can post mortems be made without the consent of the authorities of the hospital and the relatives of the deceased?

Dr. E. R. Crew, treasurer, Ohio Hospital Association: To hold an autopsy without consent of the nearest of kin is a tort. Holdings of courts in various states differ.

One superintendent declared that the physician should refuse to sign the death certificate unless an autopsy was held; the matter should then be referred to a coroner who will order an autopsy.

Objection to this suggestion was made by a gentleman from Minnesota who said that in his state when a coroner steps in an inquest is necessary, and inquests are costly.

QUESTION 11. How many interns should a 200-bed hospital have?

Dr. Lewis A. Sexton, Hartford (Conn.) Hospital: This depends upon the type and assignment to duty. More are needed in a hospital with a teaching connection. A survey of 24 non-teaching hospitals averaging 200 beds showed the following results:

Two hospitals had two interns; two had three; three had four; two had five; five had six; one had seven; one had eight; one had nine; one had 10; two had 12; one had 16; one had 19; and one had 21.

Of these 20 hospitals have rotating service; 17 have twelve months' service; and 12 pay their interns. The average of those surveyed have one intern for each 27 patients. A more ideal number for a 200-bed institution would be eight interns.

QUESTION 12. Should the hospital, realizing that the patient is not receiving all the necessary treatment, and the patient's people feeling the same, permit the patient to change doctors while in the hospital?

Mr. Frank E. Chapman, Mount Sinai Hospital, Cleveland: That is up to the patient. It is within the province of the patient in the private pavilion to change doctors if he wishes. Since it is the hospital's duty to see that the charity patient get proper service, it is up to the hospital to see that he gets it.

The tongue of the wise is health.—Prov. XII:18.

IOWA SANATORIUM ASSOCIATION IS NEWLY ORGANIZED

Sanatorium officials of Iowa, to the number of sixteen, met Saturday, September 30, at the State Sanatorium at Oakdale. The purpose of the meeting was the formation of an association for the consideration of sanatorium problems. The Iowa Sanatorium Association was formed, with Dr. H. V. Scarborough, superintendent of State Sanatorium, as president. Miss Charlotte Garrison, superintendent of Sunny Crest Sanatorium, Dubuque, was named secretary. Topics of interest in the institutional treatment of tuberculosis were discussed, featuring rest and exercise, clinic development, etc. Inspection of the new building at Oakdale and observation of a pneumothorax completed the day.

Among those in attendance were Dr. John Peck, clinician and president, Iowa Tuberculosis Society, Des Moines, and Dr. J. W. Kime, legislator and superintendent, Bowlder Lodge Sanatorium, Fort Dodge; Miss Ellen Standing, superintendent, Sunny Slope Sanatorium, Ottumwa, had the distinction of presenting her full board of trustees, Mrs. W. C. Newell, Mrs. E. J. Emery, Messrs. J. W. Calhoun, D. P. Barton and Dr. E. T. Edgerly, medical director. Pine Knoll Sanatorium, Davenport, sent Dr R. P. Carney, medical director, and Ethel Cross, R.N., superintendent. The State Sanatorium was ably represented by Drs. H. V. Scarborough, J. E. Dvorak and M. A. Cunningham. Sunny Crest Sanatorium at Dubuque sent Dr. J. C. Painter, medical director, and Charlotte Janes Garrison, R.N., superintendent.

The next meeting will be held in Cedar Rapids in February, following the annual conference of the Iowa Tuberculosis Association.

IN THE HOSPITAL

The doctor smiled, and said, "You may go home
Tomorrow;" and he looked surprised when I
Returned no answering smile. How should he know
The sudden shrinking of my tortured flesh
From all that "going home" implies to me?
I am so tired—so tired! And when I think
Of taking up the burdens that I dropped
When sickness bought for me a breathing space—
The grimy, odorous clothes, so hard to rub
To whiteness as I bend above the suds;
The food that must be bought, prepared and cooked;
The constant struggle to keep up the rent,
So that our poor, cheap sticks of furniture
May not be set out in the public street,
(Ah, God! that fear looms chief of all my fears!)—
Then is it strange that I should weakly cling
To this white cot, this atmosphere of rest,
Where I may sleep, afar from vendors' cries,
And noisy brawlings from the flat next door?
I almost hoped this pain would end all pain;
But no; the verdict's "Life!" I must "go home!"

—Florence Van Cleve in *Handbook of Organization and Method in Hospital Social Service.*

There's one of me that's humble, one that's proud;
There's one that broken hearted fir his sins,
And one who, unrepentant, sits and grins;
There's one who loves his neighbor as himself,
And one who cares for naught but fame and pelf;
From much corroding care I should be free
If once I should determine which is me."

—Selected.

THE MODERN HOSPITAL'S CONTEST FOR SMALL HOSPITAL PLANS ANNOUNCED

SUPERINTENDENTS of small hospitals and hospital workers and architects generally, manifested instant interest and enthusiam at the announcement of the architectural competition for small hospital plans to be conducted by THE MODERN HOSPITAL which was made by President George D. O'Hanlon at the opening session of the twenty-fourth annual conference.

This $1,000 competition has as its dual purpose the stimulation of small hospital construction which is efficient in arrangement, suitable for small communities and creditable in architecture and the provision to boards of trustees of small hospital floor plans that will combine simplicity of design and good taste with a compact arrangement of the various departments of the hospital now regarded as essential to the efficient and scientific care and treatment of the sick.

After looking over the general program of the competition, which was freely distributed at THE MODERN HOSPITAL booth, a number of architects expressed their approval of its method of conduct and purposes and signified their intention of entering the contest.

Even Superintendents Will Compete

Superintendents of several small hospitals then took up the cry announced that they too would consider entering the architectural competition. This they mean to do, they declared, by sketching their idea of what constitutes the ideal small hospital for their particular community and submitting these sketches to their local architects for drawing and elaboration.

The competition calls for a set of plans of a general hospital of from 30 to 40 beds. Registration for the contest must take place on or before November 15, 1922 and the final date for submitting designs is January 15, 1923.

The complete program of the competition follows:

1. PURPOSE OF COMPETITION: (a) To stimulate the building of small hospitals that are sufficiently arranged, suitable for smaller communities, as well as architecturally creditable; (b) To bring to the trustees of small hospitals floor plans that shall combine simplicity of design and good taste with a compact arrangement of the various departments of the hospital now regarded as essential to the efficient, scientific care and treatment of the sick.

2. MANAGEMENT OF COMPETITION: The competition will be conducted through THE MODERN HOSPITAL magazine with the cooperation of the leading architectural journals. The Modern Hospital Publishing Co., Inc., has appointed Richard E. Schmidt, of the firm of Richard E. Schmidt, Garden and Martin, 104 South Michigan Ave., Chicago, Ill., as the architectural adviser. He will determine and promulgate all details not herein set forth and necessary for the purpose of the competition, and all directions issued by him shall be supplemental to this program and as binding as if incorporated herein. He shall examine the designs to ascertain whether or not they comply with the terms of the competition and shall exclude any which do not.

3. JURY OF AWARD: The jury will be composed of two architects, two hospital superintendents and a graduate nurse who has had experience as the superintendent of a small general hospital; all to be selected by the chairman of the committee on competitions of the Illinois Chapter of the American Institute of Architects. The names of the jury will be announced before the closing date of the competition.

The jury will meet in Chicago or some other city to consider the designs and will place in their order of merit by secret ballot and majority vote, the five designs which appear to be the most meritorious. In reaching its decisions the jury will consider the merits of the designs, the merits of the plans from the standpoint of economy in construction and efficient operation, the integrity of the presentation and such other points as they may deem best, and award the three prizes and the two honorable mentions according to this program.

The award of the jury shall be final and binding on The Modern Hospital Publishing Co., Inc., which agrees to award the prizes and honorable mentions as follows:

4. AWARD OF PRIZES: To the author of the design placed first by the jury The Modern Hospital Publishing Co., Inc., agrees to pay the sum of $500 in cash as a prize, payable as follows: $300 immediately upon the award and the balance upon receipt and acceptance of tracings in ink on tracing cloth of the original competition plans, elevations and details and bearing the name of the author as architect. Such tracings to be suitable for blue printing. No tracing is required of the perspective drawing.

The drawings placed first and the tracings shall become the property of The Modern Hospital Publishing Co., Inc., but nothing in this agreement shall prevent the author from making individual use of his design, should he desire to do so.

To the author of the design placed second by the jury, The Modern Hospital Publishing Co., Inc., agrees to pay the sum of $300; and to the author of the design placed third by the jury, the sum of $200, said sums to be paid immediately upon the award.

To the authors of the designs placed fourth and fifth, The Modern Hospital Publishing Co., Inc., agrees to award honorable mention in the form of suitably inscribed certificates.

5. PUBLICATION OF DESIGNS: Thirty designs more or less will be selected for publication in book form. All designs awarded prizes or selected for publication shall become the property of The Modern Hospital Publishing Co., Inc., as their interest may appear and shall bear the author's name and address as architect, but nothing in this agreement shall prevent the author from making any individual use of his design that he may desire.

The Modern Hospital Publishing Co., Inc., shall be permitted to reproduce any drawings submitted in the competition in any manner it desires providing that every reproduction shall bear the author's name and address as architect, and may retain them for this purpose for three months after the award of the jury has been made.

6. DRAWINGS TO BE SUBMITTED: Each hospital submitted in this competition shall be illustrated on fairly heavy sheets of white paper. Mounting and very thin paper or cardboard are prohibited. It will be preferable to place the perspective and plat plan on one sheet; the floor plans on a second sheet; and the two elevations and section on a third sheet. All three sheets

shall be of the same size. All drawings submitted shall be packed flat, and adequately protected to prevent breaking, creasing or crushing.

A competitor may submit only one design; plans, elevations and sections shall be drawn to the scale of 8 feet to the inch. Each sheet shall have a border line half an inch from each edge. Plans, elevations and sections shall be in ink and shall have all walls blocked in solid with black ink.

The perspective shall be in pen and ink without wash or color, and may have accessories such as trees, shrubbery, automobiles and persons.

Dimensions of all rooms shall be noted in numerals and letters about ¼" high. Each room shall be numbered and its use indicated by a legend appearing at the side of the plan and numbered to correspond.

A graphic scale and the points of the compass must appear on the drawings. One of the drawings should show the principal approaches, such as the main entrance, the ambulance entrance, the service entrance, driveways, streets and alleys, as well as contour line, if any.

The illustrations required are the perspective drawn at a scale of 8 feet per inch; elevations of two sides not shown in the perspective, floor plans of all floors and basement, and wall section showing height of stories, including basement.

REQUIREMENTS OF THE HOSPITAL: The capacity shall not be less than 30 or more than 40 beds.

(a) Rooms and Wards

1. Private and semi-private rooms (single and double rooms, some with private baths and water closets) ..... 16-20 beds
2. Women's ward .....4, 5 or 6 beds
3. Men's ward .....4, 5 or 6 beds
4. Maternity ward .....one or two 2 bed or one 4 bed
5. Children's ward .....one 4 bed
6. At least 2 one bed rooms accessible to the wards for recovery and segregation.

The number of private rooms may be more than sixteen but not more than twenty; the capacity of the women's and men's wards may be four, five or six beds, or, on one or more additional four-bed wards may be introduced.

There shall be at least 80 sq. ft.* of area per bed in the wards for adult patients, and not less than 60 sq. ft. in the children's ward.

(b) Services

There shall be separate services for private and ward patients and at least one complement on each floor, designed for use of patients.

1. Charting space.
2. Medicine closet and sink.
3. Pantry, 130 to 160 sq. ft.
4. Utility room, not less than 120 sq. ft.
5. Linen closets not less than 50 sq. ft., or linen room not less than 100 sq. ft.
6. Janitor's closet.
7. Supply closet.
8. (Additional conveniences optional.)

(c) Verandas

There shall be at least three separate veranda spaces, —for ward patients, private patients and children.

(d) Operating Department

Operating room, not less than 15 ft. wide and 15 ft. long.

1. Sterilizing room, 180 sq. ft.
2. Doctor's scrub-up room, 65 sq. ft. (may be combined with doctors' dressing room.)
3. Doctors' dressing room with lockers and toilet, 100 sq. ft.
4. Nurses' dressing room with lockers and toilet, 100 sq. ft.
5. Nurses' workroom, 180 sq. ft.
6. Anesthesia room, 100 sq. ft.
7. Minor operating room planned to serve as an emergency or delivery room; suitable also for dental, eye, ear, nose and throat and for systoscopic work, not less than 14 ft. wide and 15 ft. long.
8. Accident receiving and surgical dressing room.
9. Birth room, not less than 14 ft. wide and 15 ft. long.
10. Nursery, 180 sq. ft.
11. X-ray room, 225 sq. ft.
    Dark room.
    Small dressing room.
    Plate storage room.
12. Clinical laboratory, 225 sq. ft.

(e) In General

1. Drug room, 150 sq. ft.
2. Waiting room for out-patients.
3. Treatment room for out-patients.
4. Clinical record room (may be combined with office or visiting doctor's consultation room.)
5. Office.
6. Reception room.
7. Visiting doctors' consultation room, 150 sq. ft.
8. Locker and dressing room with bath for graduate nurses, 150 sq. ft.
9. Kitchen, including facilities for the preparation of special diets.
10. Cold storage room.
11. Storage for groceries.
12. Officers' dining room.
13. Nurses' dining room.
14. Helps' dining room.
15. Resident physician's bedroom and bath, 120 sq. ft.
16. Superintendent's bedroom and bath.
17. Two bedrooms for male help, with bath room.
18. Two bedrooms for female help, with bath room.
19. Laundry.
20. Clean linen room.
21. Boiler room, (but not lighting or power plant) and coal bin.
22. Storage rooms for miscellaneous supplies.
23. Lavatories and toilets, as required.

The buildings should be planned to admit of expansion and the drawings should indicate the direction of this expansion.

It is assumed that the nursing staff will be accommodated outside of the hospital.

For the care of contagious diseases the hospital contemplates building a small isolation cottage. Its inclusion on the plat is optional.

Inasmuch as it is the purpose of the competition to bring out new thought, competitors are free to introduce into the plan elements which they regard as desirable, which are not specifically included in the slated program.

Obviously, provisions should be made for such necessary parts as elevators, stairs, dumb waiters, soiled linen chute, boiler flue, etc., etc.

8. *ANONYMITY AND TRANSMISSION:* No name or mark or sign shall be placed on the drawings or on the package containing them by which the author may be identified. (If the sender's name and address be required

*All areas stipulated in this program are expressed in feet and are mandatory minima.

on the package, as in mail or express, a name of a representative may be substituted for that purpose). No competitor shall reveal either directly or indirectly the identity of his design or hold any communication regarding the competition with any member of the jury. With each set of drawings, which shall be packed flat and adequately protected to prevent breaking, creasing or crushing, there shall be enclosed a plain, opaque, sealed envelope, without any superscription or mark of any kind, containing the name and address of the competitor. These envelopes shall be opened by the architectural adviser after the selection has been made by the jury. The opening of the envelope containing the name of the author of the design placed first by the jury will automatically make this program a contract between the author and The Modern Hospital Publishing Co., Inc.

Competitive drawings shall be addressed to The Modern Hospital Publishing Co., Inc., 22 East Ontario Street, Chicago, Illinois, in plain lettering, and delivered at this address or to the postoffice or express company not later than January 15, 1923.

Packages thus addressed will be opened and each sheet and the envelope therein given a distinctive mark. The envelopes will remain unopened until the awards are made by the jury.

Drawings are at the author's risk until returned, although reasonable care will be taken in their handling and keeping. Drawings not receiving prizes or not selected for publication will be returned to their respective authors immediately after the judges have made their awards.

Contestants are expected to register their intention of entering the competition on or before November 15, 1922, with the architectural adviser.

9. *COMMUNICATIONS* (Mandatory): If any competitor desires information of any kind whatever in regard to the competition or the program he shall ask for this information by anonymous letter addressed to the architectural adviser, and in no other way, and a copy of this letter and the answer thereto will be sent simultaneously to each competitor, but no request made after December 15, 1922, will be answered.

MAKING THE HOSPITAL CAMPAIGN A SUCCESS

"Carl N. Garland made the following statement of methods used in the community campaign for $150,000 for the Billings (Montana) Deaconess Hospital, of which he is superintendent: 'The situation here was one of extreme pessimism, and a campaign of optimism necessarily preceded any attempt to secure money. Apart from an atmosphere of assurance, which was necessary on my own part, and which was manifested on all occasions, and in the face of all opposition, it was found exceedingly valuable to organize a Deaconess Hospital Auxiliary, composed of the leading executive officers and one or two others of the respected Protestant women's organizations. My communications were necessarily read before the lodges which was distinctive publicity in itself. Their response, which was immediate, secured me a group of the most prominent women in the city, who having once identified themselves with the movement, were committed to its success and began at once boosting. Public announcements from time to time indicated the needs and assurance of the hospital.

Members of Organizations Interviewed

'The next move was to interview individual members of all the organizations in the city, cultivate a friendly attitude and convert them into champions of the cause. Having secured their confidence, it was possible to count upon their action in their respective clubs and fraternities. Being assured of such a friendly nucleus in each organization, a communication was sent to their respective secretaries, with a comprehensive statement of the Billings Deaconess Hospital program and its needs. The promised returns from the standpoint of the special service it would render in the interest of the particular club were stressed. If the communication was to a church, its generous philanthropy was urged, if to a commercial club, its distinctive economic value to the city was pointed out as well. If it was to a rotary club, the appeal was to civic pride in securing such an institution. Resolutions of support and endorsements formed the basis of a good advertisement, which was published on the eve of the campaign, showing how everybody favored the project. In fact, the setting up practically compelled the sympathy and support of all, as no organization would care to be called antagonistic in the face of such universal public support.

Business Men Made Team Captains

'Team captains were secured who were, from the standpoint of the campaign, the most prominent men in the business life of our city, and preparations were made for a large group of canvassers. Arrangements were entered into with the press whereby they published the educational material some six weeks or more in advance of the campaign, and articles were sent to all the papers within a radius of one hundred and fifty miles. I secured the cooperation of the Masonic, Odd Fellow, and Pythian bodies, having them prepare a letter to the membership of the lodges throughout the territory from which we were seeking support. This letter was signed by the chief executive officers of the local lodge, sent to the secretary of the different outside lodges and signed by him and forwarded from the local postoffice.

'I then prepared a letter signed by the executive committee, which with a folder and the campaign literature was forwarded to the entire population.

'We were now ready for action, and in the face of a three year drouth, which quite paralyzed the prosperity of this section of the country, with finances in a most stringent condition, and in the face of a falling wheat market, against the opposition of practically the whole board of directors, who feared failure because of their lack of faith in the resources of the country, in three months, over $100,000 was subscribed.' "—RALPH WELLES KEELER, Director of Publicity for Hospitals and Homes of the Methodist Episcopal Church.

EVERY MAN HIS OWN PAYMASTER

There are many paymasters back of every pay check, and back of yours are our customers, our visitors, our prospects, all those to whom we write, all the people through whose hands our goods may pass and all who have occasion to judge our service down to the final recipient or consumer of our goods. The people from whom we buy—yes, even competitors into whose hands our goods may fall and be judged—all these are your paymasters.

Inasmuch as your work helps to determine the standards of quality and service for which we strive and as these standards reflect credit to all who take a part in the routine or conduct of this business and because of the fact that your success depends first of all upon the success of those with whom you are associated—You are in the last analysis Your Own Paymaster.

REPORTS SUBMITTED TO THE CONVENTION

REPORT OF THE BOARD OF TRUSTEES

SINCE the last report to the association, your trustees have held six regularly called and one unofficial or impromptu meetings. The impromptu meeting was made possible by the presence of a majority of the members of the board in Chicago, March 9-10, in attendance at the sessions of the American Conference on Hospital Service. At each of the meetings the president presided.

A statement of the financial transactions classified into a formal report is sent to each trustee every month. These reports are given consideration at each meeting and keep the trustees informed at all times as to the financial conditions of the association. The changes in the membership roll of all classes are also reported to the trustees each month.

Only a few of the specific acts of the board can be reported here. The decisions to be mentioned in this report are those which appear to have direct bearing on the conduct, the discussions and the possible acts of this conference. The plans and facilities for the conference itself, however, speak for themselves.

The following resolution recommending the enlargement of the nominating committee was passed at the meeting in West Baden, September 16, 1921:

Voted: That the trustees recommend to the constitution and rules committee that they consider the question of enlarging the nominating committee from three to five members that all the natural geographical sections of the hospital field may be represented thereon.

At the meeting held in New York, January 12, resolutions were adopted recommending to the committee on constitution and rules the extension of active personal membership to include "the executive officers of any state—or nationwide organization having as its primary purpose the development of hospitals and hospital service." It was also recommended to include the retiring president among the ex officio members of the board of trustees.

Between busy sessions, Dr. A. R. Warner, executive secretary, and Dr. E. R. Crew of Miami Valley Hospital, Dayton, found time for a chair ride on the Boardwalk.

Uniform Constitutions for Sections

The need for uniformity in the constitutional provisions for personal membership in the American Hospital Association and in all of the Geographical Sections was discussed by the trustees at this same meeting and by appropriate resolution they expressed their opinion that harmonious and effective organization required their uniformity. The president was authorized and directed to call a meeting of the officers of the Geographical Sections to determine upon a wording of these provisions acceptable to all.

The trustee section which holds its first session with this Conference was authorized at the West Baden meeting September 16.

At the first meeting of the present board, there was discussion of the need of the association for an immediate increase in the available funds and the raising of a guarantee fund. "It was the consensus of opinion of the trustees that at the present time it was better for the Association to make further attempts to provide itself with the necessary funds through increase in memberships before asking contributions to a guaranty fund. It was, therefore, voted that the association should at this time make direct appeal to all state, city and other hospital associations and to all institutional and personal members to assist in the securing of additional memberships to the end that funds now urgently needed for the development of the association and its service to the field be in this way provided."

The report of the committee supported by the Rockefeller Foundation to work out plans for the training of hospital superintendents was considered at the meeting in Chicago, June 16. The two following resolutions were unanimously adopted:

RESOLVED: That the trustees of the American Hospital Association do hereby express unqualified approval of the report of the special committee appointed by the Rockefeller Foundation for the study of the training of the hospital superintendent, both as to the principles set forth and the statements made and also as to the suggestions for future procedure and action; and be it further

RESOLVED: That the trustees do hereby urge upon the Rockefeller Foundation and other institutions which can make practical contributions thereto consideration of the suggestions in this report as to future action, that the actual training of hospital superintendents in the required numbers and along the lines suggested by the report may be accomplished at the earliest possible date."

This report will be discussed in the administration section.

The plan for the exposition committees serving at this conference was developed and authorized at the meeting held in the Bellevue Hospital, January 12.

At this meeting, the regulations were drawn requiring that the approval of all reports and bulletins by a committee of the trustees be secured before publication and distribution.

A committee of the trustees was appointed to work out a plan for voting better suited to the present size and constitution of the association than the past routine. This committee reported at the meeting held in Chicago, June 16. The details of this report, which was approved by the trustees, have been published in the Bulletin, in the magazines, and otherwise announced. The registration for this conference in proceeding on this basis. Every person entitled to vote should become familiar with it.

It is the opinion of the trustees that the past year has been a prosperous one for the association and that distinct progress was made.

REPORT OF THE EXECUTIVE SECRETARY

The progress of your association in the past year markedly exceeded that of the previous year. The reports of the trustees, of the membership committee, the treasurer, and all other reports will attest this. We are meeting for the first time in a building designed and used for the meetings of national groups; we have outgrown even the largest hotels. This conference, this attendance, this program, the special reports which have been prepared with so much care and the exposition in the adjoining hall speak for themselves.

There are, however, a few facts about the past year which must be told—facts which account for the accomplishment of the foundation work, for the acceleration of progress and for the energy that has made the wheels move the faster.

For the last four years to the personal knowledge of the writer, your trustees have exercised a progressively increasing degree of control and supervision over the activities of the association. Matters that were a short time ago routine decisions in the office of the secretary are now determined by vote of the trustees after mature consideration of the question. This is the real basis of the recent growth in the activities of the association and this is the guarantee of further development.

The number of those willing, even anxious to work hard with the association on committees or alone for the common welfare, for service to the field and for the advancement of the association seemed multiplied many fold. Any call was responded to as never before.

To those who have served on official committees the association will express its thanks, but to those unnamed, numbering many times more, who have responded just as cheerfully to the call for work and who have made equally good at the tasks set before them, the writer desires to express for the officers of the association our thanks and high appreciation. We wish also to transmit to them the sincere gratitude of the institution and persons helped. The superintendent who compiles facts and figures for others and considers problems existing in another institution is certainly one who is effectively doing the real work of the association and rendering service to the field.

Type of Correspondence Changed

The tenor and type of the correspondence changed in several ways. The letters requesting information or presenting problems for consideration were written, not to a person but as to an institution. They simply assumed that such was the routine procedure to learn of compiled facts or to get a consensus of opinion of the best informed. To the answers many, even hundreds of persons and institutions both within and without the association, contributed. There was also the general assumption that the association existed for the development of the field and belonged to the field.

There has been more correspondence with the trustees of hospitals and more letters from outside sources seeking general information concerning the field. Many letters also indicated that the association had become more widely known.

The stronger position of the association is reflected in the exposition. The increase in size this year is through the addition of new lines and larger, stronger firms more nearly representing basic production. We could not have secured an exposition like this last year even by the expenditure of great effort. It came of itself this year.

In our accomplishment we are happy, but compared with the opportunities and possibilities clearly open to an association of the American and Canadian hospitals and hospital people they seem so meagre—even for a single year work.

Your executive secretary evaluates all facts, figures and evidences of the activity of the association in terms of their contribution toward the development of a stronger active organization of the hospitals and hospital people to build their betterment and that they may have more to give in public service,—the kind of an organization that many industries have developed to advance their interests in every way and to improve their production, the kind that impels every member to take pride in his membership and use it, the kind that returns to each member in knowledge gained and in stimulated action a value many times any membership fee. The common responsibilities of hospitals through their trustees and managers under any name demands such an active and general organization, both for the protection of the institutions and in the interests of the public. These responsibilities are increasing with each advancement in the medical science and every development or standardization of institutional activity.

Liabilities of Hospitals Increase

It can not be forgotten that every patient must necessarily stake his all on that one particular hospital. No other aid can reach him. It is this fact that makes the management of every hospital so serious a trust. Who is to blame when a hospital loses lives from a high percentage of infections? The various alibis advanced by hospital trustees and managers when in trouble become of no practical moment in the face of the growing unanimity in supreme court decisions. These are placing a steadily increasing responsibility upon the institutions themselves, demanding from their managers a proper protection of the public as their function and duty.

The big problems and responsibility of any board of trustees and any superintendent are to know what is the best service, what are the best policies and practices, what are the best end results that can be attained and how to get them in their hospital. Can they ever know or even be reasonably assured from their own experience and performance alone that they have the best or that their results have required only a justifiable expenditure of money and effort? To know this constant contact with the rest of the field it is essential that there may be the necessary comparison, and comparisons reduced to equal terms. There is need at reasonable intervals for the stimulus from personal contact and contentions with others facing the same problems; there is need for the actual seeing, handling and study of the improved productions in equipment and materials used; there is need for thinking that daily routine will never provoke or permit; there is need for an organized way to ask a question that the quesions of all may be answered without imposing burdens; there is need for concerted action and the establishment of recognized standards of work.

The American Hospital Association was organized, developed and exists to act as the medium and means through which all this may be accomplished and to aid all hospitals and their trustees or managers under any name to fulfill the trusts and duties they have assumed.

Dr. Henry Ladd Stickney of the U. S. Public Health Service Hospital No. 53, Dwight, Ill., has accepted the position of superintendent of the Presbyterian Hospital of New Orleans.

REPORT OF MEMBERSHIP COMMITTEE

Your membership committee begs to submit the following report of its work during the past year.

Your committee has received, considered and either approved or disapproved of all applications for institutional membership, and all applications for personal membership, except those submitted by the Geographical Sections. The membership committees of the several Geographical Sections pass upon all applications for personal memberships in their respective states and routinely report accepted members to the office of the executive secretary of this association.

Our report includes many new personal members, the figures submitted combine those approved by your committee, and those recommended by the Geographical Sections.

INSTITUTIONAL MEMBERSHIP

ACTIVE

Institutional members on roll at last conference		358
New members accepted since last conference		110
		468
Resignations		2
Number on roll Sept. 1, 1922		466
Net increase for the year 108, or 30%. To be compared with a net increase last year of 48, or 15%.		

ASSOCIATE

Number on roll Sept. 1, 1922		7
(This form of membership did not exist last year.)		
Total number of institutional members of both classes, Sept. 1, 1922		473

PERSONAL MEMBERSHIP

HONORARY

Total number of honorary members	10
(No change this year or last year.)	

LIFE

Active:			
Total number of active life members		26	
(No change in the past year.)			
Associate:			
Members on roll at last conference	5		
New members accepted since last conference	1		
Number on roll Sept. 1, 1922		6	
Total number of life members of both classes, Sept. 1, 1922			32
Net increase for the year, 1, or 3%. To be compared with a net increase last year of 15, or 93%.			

ACTIVE

Members on roll at last conference		1,082	
New members accepted since last conference		260	
Associate members transferred to active membership		2	
		1,344	
Resignations		88	
Number on roll Sept. 1, 1922			1,256
Net increase for the year, 174, or 15%. To be compared with a net increase last year of 207, or 23%.			

ASSOCIATE

Members on roll at last conference		204	
New members accepted since last conference		65	
		269	
Resignations	22		
Members transferred to active membership	2		
		24	
Number on roll Sept. 1, 1922			245
Net increase for the year, 31, or 15%. To be compared with a net increase last year of 17, or 9%.			
Total number of personal members of all classes on roll, Sept. 1, 1922			1,543
Net increase for the year, 216. To be compared with a net increase for last year of 238.			

Your committee wishes to call the attention of the association to the constitutional provision creating associate institutional membership. This class of membership was added at the meeting a year ago, so that organizations connected with or interested in hospitals might have direct information from this association concerning hospital work and also receive the literature sent out by this association. The members accepted under this constitutional provision include:

One national department having jurisdiction over the hospitals of the nation—namely, Department of Health, New Zealand.

One state department having jurisdiction over the hospitals of the state—namely, The Pennsylvania Department of Public Welfare.

One university medical college—namely, Cornell.

One new type of organization in the hospital field—namely, The Joint Administrative Board of Columbia University and Presbyterian Hospital.

One state organization of hospital department work—namely, The Illinois Society of Occupational Therapists.

One national committee—namely, The National Hospital Day Committee.

And one, only one organization of a hospital—namely, The Woman's Auxiliary Board of the Presbyterian Hospital of Chicago.

We can safely say that the desire for routine information as to the activities of this association prompted each of these applications.

It is clearly to the best interests of every hospital and every hospital executive that all organizations connected with hospitals affiliate themselves with this association in this way, thus receiving the literature sent out by the association and obtaining the trend of thought and action as expressed in and through the association.

We cannot close this report without asking the following question: Why are the organizations so few and in such a minority when they can be so readily reached by the hospital executives represented in the above membership?

Respectfully submitted,
WALTER H. CONLEY, Chairman.
C. J. CUMMINGS.
CHARLOTTE J. GARRISON.

SOME VARIATIONS IN THE PROGRAM

Several of the speakers scheduled for the convention program were compelled to cancel their speaking engagments at the eleventh hour. Among these was Dr. Royal S. Copeland, commissioner of health of the city of New York, whose name was presented during that week as a candidate for governor of New York. A. O. Fonkalsrud of Minot, N. D., who was down for an address on "Some Essentials in Hospital Organization," was unable to be present on account of an intensive financial campaign in progress at his hospital.

Governor Edward I. Edwards of New Jersey sent a substitute to welcome the delegates to the state and Atlantic City. Dr. Haven Emerson, professor of hygiene and public health at Columbia University, also was unable to be present, but sent his paper for the dispensary section on "The Educational Value of the Out-Patient Department in Relation to the Patient and the Community."

The American Occupational Therapy Association members deeply regretted that their president, Dr. Herbert J. Hall, was not sufficiently recovered from his illness to attend its sessions.

An unscheduled visitor and speaker was Commissioner Bird T. Coler of the department of public welfare, New York. Edwin R. Embree, secretary of the Rockefeller Foundation, who has recently returned from the Orient, was a convention guest and talked briefly on hospital conditions in China.

"Be a judge of the work of others of whom you are in charge, not a detective; your mere detective 'is wonderful at suspicion and discovery,' but is often at fault, foolishly imagining that every one is bad."—Florence Nightingale.

FLOORING COMMITTEE SUBMITS NOTABLE REPORT*

AT THE beginning of this survey a questionnaire was developed in collaboration with architects, hospital superintendents and manufacturers of flooring material that attempted to visualize the needs of hospitals and to secure a composite evaluation of the pertinent requirements of various types of hospital service.

The results of this questionnaire were far from satisfactory. Out of the number sent, approximately 1,700, ten complete replies were received, with a total response of not to exceed twenty-five. Most of the replies expressed an absolute ignorance of the individual as to the basic requirements of the ideal floor or floors and how to obtain them. However, the expressed evidence of interest in the result of the study but emphasized the need for the analysis.

By reason of the failure of the questionnaire to produce a volume of replies that would warrant it being considered the composite opinion of the hospital field, it was felt after consultation that some means of formulating an opinion and basing recommendations should be developed. To that end the committee developed a series of laboratory tests, the results of which are included in this report and in the exhibits accompanying it. The results of some of these tests cannot be graphically illustrated, and an inspection of the exhibits is prerequisite to a thorough understanding of the recommendations.

It first of all must be definitely understood that the committee does not presume to suggest that the most ideal laboratory tests are all-conclusive. After all, the true test of any commodity is the actual service that it renders under normal conditions of service. These laboratory tests are the result of considerable thought and attempt to determine in an approximate way only the various relative properties of all of the floor samples submitted. The detail of the tests are as follows:

Test No. 1—ABRASION.

The purpose was to ascertain the relative wearing quality of samples submitted. Comment may be made that the test is more harsh than the usual floor will receive under normal wearing conditions. However, in view of the fact that all samples were submitted to identically the same test, comparisons are fair.

The procedure of the test was that the sample was mounted on a firm foundation and submitted to an emery wheel without pressure other than the pressure of the wheel, for a period of five minutes.

Test No. 2—RESISTANCE TO PRESSURE.

None of the so-called hard type of floors were submitted to this test. The purpose was to determine the degree of pitting under average hospital service.

The procedure was that samples were placed on a firm foundation and had applied to them (under fifty pounds of press ure), a metal surface similar to that used for protecting table and chair legs, for a period of thirty days.

Test No. 3—FIRE RESISTANCE.

The purpose was to establish how the material would stand up under the very common practice of throwing lighted cigarettes on the floor.

Completely lighted cigarettes were placed on the sample and permitted to burn out entirely.

Test No. 4—ABSORBENCY.

The purpose was to determine the condition of floors after usual cleaning procedures for a period of time. There is a certain group of flooring material that if examined at the base after a year or so of service will evidence a degree of filthiness due to absorbency of mop water that would absolutely preclude their use in a hospital.

The procedure was to weigh the sample carefully on an accurate scale, immerse completely in water for twenty-four hours, remove from water and immediately weigh, and re-weigh at five day periods for fifteen days, indicating the percentage above normal at each weighing period.

The following table in the next column indicates the results.

Test No. 5—ACID AND ALKALI RESISTANCE.

This test is self-explanatory and the purpose self-evident.

Samples were submitted to application of concentrated nitric, sulphuric, hydrochloric, oxalic and acetic acids. No attempt was made to remove solutions applied.

Test No. 6—STAINING.

Tho purpose and desirability of this test are equally as evident as test No. 5. Floors were submitted to applications of hot grease and blood for staining and applications of methylene blue, carbofuxine and iodine to show capillarity and absorbency.

Superficially it would appear that a discussion of floors should take into consideration only the commodity of which the wearing surface is made, but as a matter of fact this commodity is but one angle in the selection of the ideal hospital floor.

		Increase in Weight 24 hrs.	Five Days	Ten Days	Fifteen Days
7	Adamantile	6%	†N	.....	.....
10	Alundum art tile	9%	4½%	4½%	†N
17	Linoleum—household (Armstrong)	*NI	.....	.....	.....
22	Asbestone	10%	5%	5%	†N
39	Terrazzo	*NI	.....	.....	.....
41	Carborundum floor tile	5%	1%	1%	†N
50	Duratex	5%	†N	.....	.....
53	Copperstone	6%	†N	.....	.....
56	Crescent cork tile flooring	33⅓%	†N	.....	.....
57	Linoleum—inlaid (Armstrong)	*NI	.....	.....	.....
58	Cork tiling	*NI	.....	.....	.....
63	Detroit brand	33⅓%	†N	.....	.....
65	Domestic quarries tile	3%	1½%	1½%	†N
66	Double diamond interlocking rubber tiling	15%	†N	.....	.....
68	Duraflex	*NI	.....	.....	.....
72	Everlastic tile	20%	†N	.....	.....
73	Feralum anti-slip	14%	†N	.....	.....
77	Flexotile	11%	8%	6%	†N
78	Flexstone	*NI	.....	.....	.....
79	Flint tile	3%	3%	†N	.....
86	Gold seal battleship linoleum	*NI	.....	.....	.....
93	Hexagonal tile (vitreous)	3%	†N	.....	.....
96	Imperial sanitary fireproof	17%	9%	†N	.....
97	Inlaid sheet tiling	19%	12%	†N	.....
100	Kellastone	25%	11%	7%	†N
101	Keystone	*NI	.....	.....	.....
102	Kompolite	24%	5%	†N	.....
105	Korkstone	12%	†N	.....	.....
109	Limestone—Indiana	*NI	.....	.....	.....
111	Linoleum—battleship (Armstrong)	20%	†N	.....	.....
116	Appalachian marble	*NI	.....	.....	.....
117	Georgia marble	*NI	.....	.....	.....
118	Mt. Nebo marble	*NI	.....	.....	.....
119	Vermont marble	*NI	.....	.....	.....
124	Masterbuilders concrete with hardener	6%	†N	.....	.....
122	Marbleloid	79%	†N	.....	.....
128	Mineral flooring	200%	150%	†N	.....
131	Nairn's linoleum (battleship)	*NI	.....	.....	.....
133	Nonpareil cork tiling	66%	†N	.....	.....
140	Protectile	*NI	.....	.....	.....
155	Selry	*NI	.....	.....	.....
157	Ceramic tile	100%	†N	.....	.....
158	Naturized rubber	*NI	.....	.....	.....
160	T. M. B.	*NI	.....	.....	.....
161	Compoloid	*NI	.....	.....	.....
164	Touraine quarries tile	10%	7%	7%	6%
168	Unico elastic tile	*NI	.....	.....	.....
170	Usco	*NI	.....	.....	.....
171	Velvetile	*NI	.....	.....	.....
172	Non-slip floor tile (carborundum)	33⅓%	16⅔%	†N	.....
174	Welsh quarries tile	3%	3%	3%	†N
178	Zenitherm art cork	20%	14%	†N	.....
179	Rub-R-Art	33%	33%	†N	.....
182	Alundum safety aggregate tile	3%	†N	.....	.....
183	Linotile	NI	.....	.....	.....
184	Cement—no hardener	10%	†N	.....	.....

*No increase. †Normal.

The base upon which a floor is to be laid is the predetermining factor in the selection of that floor. In newer types of construction those entrusted with construction are met with probably only one kind of base, either a finished or unfinished concrete slab. There is, however, the problem of old installations requiring the laying of floors over an old wooden base (or one of a comparable nature); any group entrusted with such an installation should know beyond a measure of doubt that the commodity it is selecting will stand up under prevailing conditions.

Of equal importance is a discussion of the type of cove, and the type of wainscoting that are to be used. Some floors permit of the installation of both cove and wainscoting as an integral part of the floor itself and of the same material. This is highly desirable under some conditions.

*An abstract of the report of the Committee on Floors presented at the twenty-fourth annual conference of the American Hospital Association by Frank E. Chapman, chairman.

The importance of a consideration of this problem is herein emphasized.

There is of course at all times the problem of first cost that injects itself into a consideration of the hospital floors. This is always a very vital factor in the determination of the flooring to be installed. It would be presumptuous for the committee to attempt to set up a schedule of floor costs, by reason of the inaccuracy of such a table. The question is merely put at this point to draw attention to several vital factors that enter into the after-cost of any installation.

The floor that requires waxing, polishing, surfacing or surface treating may produce a maintenance cost per yard per year that will more than offset the difference between it and another of a higher initial cost. Therefore it is recommended that consideration be given to the procedures of maintenance and the cost thereof, in determining whether or not the initial cost is high.

Another phase in a determination of flooring installation is the relative expectancy of usage. It is needless to say that a floor which will last fifteen years at an initial cost of $1.00 a foot is less expensive than a floor that will last five years at an initial cost of fifty cents a foot.

Were we able to develop a monolithic type of floor that would remain as originally installed, without joints and crevices, there is no question but that that floor would be the ideal floor from the standpoint of sanitation, maintenance and appearance, and if with that type of floor we could secure comfort and noiselessness, we would have obtained the ideal hospital floor. But, as a matter of fact, with expansion and contraction incident to all types of construction, monolithic floors never retain their original form, and as a consequence we have expansion and contraction cracks that must be resurfaced. The problems of durability, maintenance, continuous availability and ease of repair immediately present themselves.

On the other hand, in the installation of other than monolithic types, a determination of the type of the floor must take into consideration the character of the joining material, in order to insure the same degree of sanitation, acid and alkali resistance and appearance in the joining material as in the flooring material proper.

A further consideration must determine whether or not the floor is an integral or surface flooring, *i. e.*, whether after a certain period of usage the surface will have been worn down and present a material that is not at all comparable in terms of efficiency to the original installation. There are certain types of flooring that offer this problem.

It is the belief of your committee that any recommendations of hospital floors must be predicated upon the ratio of evaluations of the pertinent requirements by individual boards of trustees. To illustrate specifically, certain types of floors have a relatively high rating in terms of ease of repair and maintenance and a relatively low rating in appearance, noiselessness and comfort. Certain other types have a high rating in appearance but a relatively low rating in ease of repair, acid and alkali resistance, etc. It is

		Abrasion	Pressure	Fire	Absorbency	Acid and Alkali	Staining
7	Adamantile	C	NT	A	B	B	E
10	Alundum art tile	A	NT	A	C	D	C
17	Linoleum—household (Armstrong)	D	C	E	A	E	C
22	Asbestone	B	NT	B	C	E	D
39	Terrazzo	A	NT	A	A	C	E
41	Carborundum floor tile	A	NT	A	B	C	B
50	Duratex	B	NT	B	B	D	B
53	Copperstone	E	NT	B	B	C	C
56	Crescent cork tile flooring	C	B	E	D	E	E
57	Linoleum—inlaid (Armstrong)	D	B	D	A	E	C
58	Cork tiling	C	C	E	A	D	D
63	Detroit brand	E	C	C	C	E	C
65	Domestic quarries tile	A	NT	A	B	C	A
66	Double diamond interlocking rubber tiling	B	B	B	C	C	B
68	Duraflex	E	NT	B	A	B	A
72	Everlastic tile	D	D	D	C	D	C
73	Feralun anti-slip	B	NT	A	B	A	D
77	Flexotile	B	NT	B	C	E	B
78	Flexstone	B	NT	B	A	D	B
79	Flint tile	B	NT	A	B	A	A
86	Gold Seal battleship linoleum	D	C	D	A	D	C
93	Hexagonal tile (vitreous)	B	NT	A	B	A	B
96	Imperial sanitary fireproof	C	NT	No	C	D	B
97	Inlaid sheet tiling	C	B	E	C	E	C
100	Kellastone	B	NT	A	D	B	B
101	Keystone	E	C	E	A	B	A
102	Kompolite	B	NT	A	C	E	B
105	Korkstone	B	NT	B	B	E	C
109	Limestone—Indiana	B	NT	A	A	C	E
111	Linoleum—battleship (Armstrong)	C	C	E	B	D	C
116	Appalachian marble	A	NT	A	A	E	E
117	Georgia marble	A	NT	A	A	A	E
118	Mt. Nebo marble	B	NT	A	A	C	B
119	Vermont marble	A	NT	A	A	C	E
122	Marbleoid	B	NT	B	D	D	D
124	Masterbuilders concrete with hardener	A-B	NT	A	B	C	D
128	Mineral flooring	B	NT	B	E	D	D
131	Nairn's battleship linoleum	B	C	E	A	D	C
133	Non-Pareil cork tiling	B	C	E	C	E	E
140	Protectile	C	NT	A	A	C	E
155	Solry	A	NT	A	A	B	E
157	Ceramic tile	B	NT	B	C	A	D
158	Naturized rubber	A	A	A	A	B	A
160	T. M. B.	E	NT	E	A	C	B
161	Compoloid	B	NT	B	A	E	B
164	Touraine quarries tile	C	NT	A	E	A	A
168	Unico elastic tile	E	C	E	A	D	C
170	Usco	C	B	B	A	B	C
171	Velvetile	NO	NT	C	A	D	NO
172	Non-Slip floor tile (carborundum)	C	NT	A	C	A	B
174	Welsh quarries tile	B	NT	A	B	A	A
178	Zenitherm art cork	C	A	C	C	D	D
179	Rub-R-Art	C	B	D	C	C	B
182	Alundum safety aggregate tile	A	NT	A	B	A	C
183	Linotile	E	C	E	A	C	C
184	Cement—no hardener	C	NT	A	B	C	E

Mr. Chapman's laboratory evaluation of flooring samples met with constant inspection.

therefore incumbent upon the individual group interested in an installation to determine which requisites are paramount in its particular case, and then to select the floor that has an index of requirements highest for its particular need.

There is a growing tendency in hospital installations today, by reason of the apparent economy of maintenance, to make installations of certain of the hard types of flooring. With our modern methods of construction, the problem of noise in a hospital is becoming increasingly obnoxious, and it is incumbent upon those entrusted with the construction of hospital buildings to offset in every way possible the disadvantage incident to concrete and steel construction in this respect, by the installation of flooring materials that will be efficient insofar as sanitation, durability, maintenance, fire resistance, ease of repair, continuous avilability, and acid and alkali resistance are concerned, and at the same time to use the material that will reduce either by absorption or by resilience the noise incident to hospital traffic. Therefore, it is believed that insofar as is possible those parts of the hospital allocated to patient occupancy and corridors should be treated with the so-called soft-type of floors. It is the belief of the chairman of this committee that this same treatment can be given in various other parts of the hospital, such as utility rooms, diet kitchens and operating rooms, but it would be presumptuous to make so radical a recommendation even though such installations have been made and are proving preeminently successful.

There is a definite objection to the soft-type of flooring in that it has not the durability of some of the other types. This objection was well founded up until the last few years. There has been, however, a development in this type of flooring that apparently has retained all of the advantages of the former group of soft floors, at the same time has overcome the objection of pitting, and seems to offer a resistance to abrasion which compares very favorably with the hard types of flooring

Based upon laboratory tests, the committee in the table on the preceding page submits a list of all floor samples submitted with a rating on their relative efficiency under the different tests.

KEY FOR TABLE PAGE 12.

A	Excellent 90-99	D	Poor 60-69
B	Good 80-89	E	Very Poor .....Below 50
C	Fair 70-79	NT	No Test.

NOTE—While most of the wood flooring associations submitted samples, no gradings are made for the reason that no sample of wood floor can in any measure approximate actual service conditions. There are conditions under which wood floors may be used in hospitals but they are special ones and do not fall within the scope of this report.

There is also submitted for consideration and proper evaluation, a recommendation as to the best type of floor for various services.

TABLE OF RECOMMENDATIONS

		Soft Type	Hard Type
1	**Private Rooms**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
2	**Wards**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
3	**Service Rooms (see note)** Utility, service kitchens, toilets, baths.		
	First choice	Reinforced rubber....	Flint tile (various colors)
	Second choice ..	Battleship linoleum...	Slate
	Third choice ...	Soft mastic.....	Concrete with integral hardener and coloring
4	**Corridors**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
5	**Service Corridors**		
	First choice	No recommendation..	Asphalt mastic
	Second choice ..	.....	Concrete with integral hardener and coloring
	Third choice ...	.....	.....
6	**Laboratories**		
	First choice	Reinforced rubber....	Quarry tile
	Second choice ..	Battleship linoleum...	Terrazzo in blocks
	Third choice ...	Soft mastic.....	Concrete
7	**Operating Rooms**		
	First choice	Reinforced rubber....	Flint tile
	Second choice ..	Battleship linoleum...	Terrazzo in blocks
	Third choice ...	Soft mastic.....	Slate
8	**Out-Patient Treatment Rooms**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
9	**Out-Patient Corridors**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
10	**Kitchens**		
	First choice	No recommendation..	Quarry tile
	Second choice ..	.....	Terrazzo in blocks
	Third choice ...	.....	Concrete with integral hardener and coloring
11	**Offices**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
12	**Laundry and Comparable Services**		
	First choice	No recommendation..	Concrete with hardener and coloring

NOTE—On baths and toilets ceramic tile can be used to very good advantage, in fact is preferable to flint tile.

Conclusion

In conclusion, the committee holds for itself no thought of omnipotence. The subject of the ideal flooring is too vast and too important to be definitely decided by any one group. The report is the result of more or less continuous study over a period of two years. It has entailed rather arduous labor that has been cheerfully expended, not only because of the momentousness of the question but because it has visualized such a great ignorance of the problem under discussion and the necessity for more and more study of the question.

ADEQUATE TRAINING FOR HOSPITAL SOCIAL WORK*

DESPITE the fact that hospital social work as an organized part of medical institutions in America is over fifteen years old, there is as yet no unified authoritative opinion as to its function, policy and educational standards. Training for a field of work cannot be satisfactorily developed without a clearly defined conception of the field. A statement of principles for the education of hospital social workers should consequently begin with a definition of the work for which we are to educate.

Briefly, the function of the hospital social worker is to deal with the patient's personality and environment in such a way as to contribute to the physician's effort to cure and prevent disease. While the worker's efforts have thus a medical purpose or application, the activities themselves are social work—the investigation and adjustment of personality and environment. The training of the hospital social worker, therefore, must include medical knowledge sufficient to make clear the application and relationships of social facts to health; but the nature of the skill sought and of the technique to be developed is essentially the skill and technique of social work.

Requirements of the Field

In hospital social work, as in public health nursing, the worker is thrown into contact with patients and families under conditions which call for tact, resourcefulness, and ability to deal not infrequently with delicate personal situations, without the possibility of immediate recourse to some superior or larger experience. A degree of maturity is, therefore, essential. This can not be expressed in years, but, in general, the committee is of the opinion that students should not be accepted under the age of twenty-one and that in judging the qualifications of a student or a prospective worker for acceptance in a school course or for employment, maturity as indicated by personality, irrespective of years, should be an important consideration.

Preliminary Education

It is the opinion of the committee that the completion of four years of college training best expresses the general preliminary education which should be required of students entering a professional course of training for hospital social work. The committee does not consider that merely holding a college degree is essential, but believes that four years of work in a good college provides the best general index of intellectual maturity and mental discipline. It is recognized that there are many persons who would be highly acceptable as students who have not had the advantage of four years in college. Training in an acceptable school of nursing, following not less than two years of college work; training and experience in general social work with similar academic background, are two illustrations of preliminary educational qualifications which might well be considered acceptable. It is desirable that the college work should include biology, physiology and hygiene, psychology, and some course in social science, such as economics, sociology, or government. Broad general culture, mental alertness and flexibility, and a command of English are of more fundamental importance than familiarity with any special subject matter.

Length of Course

The course of training should cover a period of two years for students not entering with advance credit.

Essential Subject-Matter

Consideration was given to the plan of preparing several different courses of combined study and practice, each adapted to students of different preliminary education and training. After careful deliberation, the committee has thought it best to draw up a single course containing all the various elements which it believes necessary parts of adequate training for hospital social work; to specify the relationships and relative time limits of these elements, and to recommend that credit allowance be arranged for individual students whenever their previous education or training enables them to present equivalents for one or another portion experience in general social work with similar academic background, are of the course. The committee believes that only by this method can there be maintained a sufficiently high standard of training, and the equally indispensable condition of flexible adaptation of the course to students of varied preparation, such as are necessarily drawn into a new vocation.

The course should include a combination of practice and classroom work. The student must acquire three things: (1) understanding of principles; (2) adequate information concerning essential professional facts, medical or social; (3) ability in technique of work. Hospital social work can not be taught by lectures, conferences, reading and classroom exercises alone, any more than can medicine or nursing. The committee believes that at least half of the entire time given to training should be devoted to practice under supervision.

The principles and method of practice should be as follows:

(1) The social service department of a hospital is the field in which the student should spend most of his time.

(2) There should also be some practice in a family case work agency in order that the work of a non-medical agency be understood.

(3) Practice in hospital social work should be carried on chiefly in a single institution in order to preserve continuity.

(4) There should be some periods of observation in other medical and public health organizations.

(5) A long, uninterrupted period of practice is highly desirable.

(6) Practice and classroom work should be closely correlated.

(7) Practice should be supervised by the agency in which it is done. The plan of practice should be subject to the educational direction of the organization giving the course.

The subject matter of the classroom work should include the following elements:

The functioning of the human body, with such information regarding structure, heredity, and development as is necessary for the proper understanding of function; essential physiological processes; personal hygiene.

Selected problems of disease studied, not from the standpoint of their pathology, but with special reference to the nature of the disability occasioned, the degree of communicability, if any, and the duration and character of treatment in its bearings upon occupation, family life and income, and the usual available medical resources.

*An abstract of the report of the Committee on the Training of Hospital Social Workers presented at the twenty-fourth annual convention of the American Hospital Association. The committee is as follows: Michael M. Davis, Jr., chairman, Dr. Louis B. Baldwin, Dr. Frank Billings, Miss Ida M. Cannon, Miss S. Lillian Clayton, J. E. Cutter, Miss Annie W. Goodrich, Miss Mary C. Jarrett, Dr. George O'Hanlon, John A. Lapp, Porter R. Lee, Roger I. Lee, Miss Kate McMahon, Dr. Lewis A. Sexton, Dr. Winfred H. Smith, Dr. Frankwood E. Williams, Dr. A. R. Warner, and Miss M. Antoinette Cannon, executive secretary.

Public health administration: The main functions and characteristic organizations of local, state, and federal health agencies, private agencies, and the chief present public health problems.
Medical institutions and organization: History and traditions of the medical and nursing professions, present day organization and problems of hospitals, clinics and private practice.
Human behavior: The functioning of mind and body, their interrelations in health and disease; psychology taught from the behavioristic point of view, with some special reference to the problems of psychiatry and of mental defect.
Community organization: The economic and social organization of society in nation, state, city and rural areas. Typical community problems, community agencies and community resources.
Industry: Characteristics and organization of modern industry and commerce, with special reference to the effects of occupation upon health.
Government: Organization of national, state and local governments, with chief reference to the working of governmental departments and agencies dealing with health, poverty, education, and with the institutional care of the dependent and afflicted.
Human adjustments: Another name for a course in social case work, dealing with the principles and methods of work with individuals and families in the endeavor to make those adjustments of personality and environment called for by various conditions and problems.
Statistics and research: Principles and methods of utilizing figures, of viewing facts critically, and of dealing with data quantitatively.

Students of psychiatric social work will need additional courses in developmental psychology and in mental disease. Their practice will be in psychiatric social work and they will throughout their training emphasize detailed study of individual behavior.

Methods of Instruction

The classroom work should place comparatively slight dependence upon formal lectures. The medical subjects, particularly those dealing with disease and with bodily functions should be elucidated by demonstration in ward, clinic, or laboratory. Informal lectures, followed by questions and discussions, appointed reading on which class discussions are based, should be utilized, and above all, the project method whereby students are assigned problems which they must work out with the instructor in class or individually.

It is essential that there be continuity of instruction.

For purposes of correlation between the classroom work and the practice, the students should be required to bring into the classroom accounts of cases or problems which come up in their practice, which illustrate or raise questions concerning the subject matter of the academic instruction.

It is the opinion of the committee that the training for hospital social work should, whenever possible, be under university auspices, and that a special school or division of this university should be constituted, dealing with training for socal work. Hospital social work would be one branch of the training given in such a school.

Miss M. Antoinette Cannon, executive secretary of the committee.

Must Adapt Course to Varied Field

Social work as an assistant to medical service appears in several different relations. Social workers are needed in organized social service departments of hospitals and clinics, but medical organizations which are too new or too small to possess social service departments need, nevertheless, to carry on social work for the benefit of their patients.

In outlining the course in training in hospital social work, therefore, there should be held in mind the needs of those who intend to enter social service departments in hospitals and clinics, and also the needs of those who will practice medical social work in connection with other activities. The committee has outlined a general course of training for hospital social work, appreciating that such a course must be adapted flexibly to the demands of students and professional workers of varied preliminary training, different practical experience, and different future fields of work; and that elements of the course may be found useful parts of other training of related vocational groups.

Discussion of the Proposed Course

From friendly critics to whom the preliminary draft of the proposed curriculum was submitted last spring, and those to whom the present draft was submitted this autumn, certain outstanding criticisms have been received, to which attention should be given. The chief objections raised to the proposals of the committee have been (1) the course is too long, (2) the entrance requirements are too advanced, (3) taking into consideration the above points and the general subject matter and method of the course, the standard is too high to attract a sufficient number of students, (4) insufficient provision is made for students who had not previously had a nurse's training, to acquire familiarity in dealing with the sick and with methods of personnel of medical institutions, (5) the amount of medical instruction offered is insufficient and likely to be a mere smattering for those who have not previously had a nurse's training, and (6) the reverse criticism is made with equal force, that too large a proportion of the course is given to medical instruction, even for those who are trained nurses, in consideration of the fact that the essential technique required is social, and not medical.

The committee has weighed with special care the six major criticisms above listed. With regard to the first three, which may be taken together, the committee is of the opinion that these criticisms are based on two mistaken points of view; (1) that the need of the field is for a large number of workers rather than for workers qualified to meet the most exigent present demands, and (2) that a course of high standard attracts but few students.

Is the Course too Long?

The committee is furthermore of the opinion that a course of two years in length is the minimum standard in order that there be sufficient time to acquire the points of view and the working habits which hospital social work demands, and which, in their nature, can not be imparted to the student in a moment. They must be the fruit of continued contact in the field and in the classroom with certain types of facts and certain groups of professional workers and patients with whom the student is engaged. Time is essential for the absorptive processes. This is particularly important in hospital social work at the pres-

ent time, since there are many students with previous professional experience who have to acquire the point of view and the technique of a new vocation.

Should Students Live in the Hospital?

After much discussion, the committee has come to the conclusion that a period of residence in a hospital is not a necessary part of the training of a hospital social worker. The large amount of practice work required in the proposed course, the major part of which is in the social service department of a hospital or clinic, will bring the student for a large part of the working time for at least one year, into continuous contact with the personnel and conditions of a medical institution. It is believed that there is insufficient reason for adding to this a requirement as to residence.

Too Much or Too Little Medicine?

The two conflicting criticisms, that on the one hand the course gives only a smattering of medical information, and on the other hand that it has relatively more than hospital social workers require, must be answered together and in two ways. In the first place, no course within reasonable limits of length can include sufficient information on any subject to suit the specialist in that subject; in the second place, the committee believes that the criticism that the course is insufficient in medical subject matter arises chiefly from a misunderstanding as to the kind of medical subject matter which should be taught.

Conclusion

It is the committee's hope that this report on the proposed curriculum will be brought to the attention of the educational institutions throughout the country which are interested in the training of hospital social workers, and that practical steps may be taken to try out the recommendations of the committee, by the modification of existing courses, or the establishment of new ones in the directions herein indicated. The test of an educational program comes in the laboratory of practical experience with the student in the classroom and in the field. The committee's curriculum includes (1) a larger proportion of medical subject matter and of practice work than is at present offered by most of the schools of social work; and (2) a much larger proportion of training in social case work and of supervised practice in social work than is offered by some of the university training schools and nursing schools. The value of our recommendations must be determined by the tests of practice.

It is recognized that conditions in universities and schools training hospital social workers vary widely, that no standardized or uniform curriculum is at present conceivable. The field of training for hospital social work is, in a measure, one of educational experimentation, and the committee offers its report with the desire that its suggestions may aid existing schools in the advancement of curricula and methods, and that it may be suggestive also to those who are considering the inclusion of social subject matter and methods in the curricula of schools of medicine, public health and nursing.

In presenting this report to the trustees of the American Hospital Association, the committee trusts that its report will be accepted and the committee discharged. The present committee has fulfilled the function for which it was appointed. It would seem, however, that some service might be rendered by a committee, primarily of representatives from the educational organizations now offering training for hospital social work, which would serve as a medium for intercommunication so that each organization may learn from the others the results of its experimentation in subject matter and method. The committee believes that training for hospital social work will proceed more rapidly, will be made more self-conscious and more helpfully critical, if some such cooperative committee among these educational institutions were in existence.

PUBLIC HEALTH SERVICE EMPLOYS MANY WOMEN

In proportion to its size, the personnel of the United States Public Health Service probably includes more highly trained and specialized women than any other branch of the Federal Government.

Highest on the list stand two officers holding commissioned rank in the reserve—Surgeons Lydia Allen DeVilbiss and Josephine Baker. Next in rank come a number of scientific and professional women, all or most of whom are physicians, though some are classified by other titles. Among these are acting assistant surgeons Blanche Sterling and Edith B. Lowry, Viola Russel, pediatrist, and Elizabeth B. Reid—all belonging to the child hygiene section; Ida A. Bengston, sanitary biologist; Alice C. Evans and Mrs. E. M. A. Enlows, bacteriologists; and Mrs. S. C. Brooks, assistant biologist, all belonging to the hygienic laboratory; Gertrude Seymour, president of the American Women in Public Health, and Drs. Daisy Robinson and Edith Rabe, regional consultants, all belonging to the venereal diseases division.

Several large groups of highly trained women have been organized in the Public Health Service. Among these are the reconstruction aides, most of whom have had college training or its equivalent, and all of whom are of unusual ability and character. These are stationed at various hospitals of the Service throughout the country. Their task is to help maimed soldiers to regain control of injured muscles and nerves or of dormant or deranged mental faculties, by appropriate physical exercises (physiotherapy) or by curative and diversional occupations (occupational therapy). The aides, who are headed by Miss Marian Morriss, number about four hundred, to whom others will be added as qualified applicants can be found.

Vying with the reconstruction aides are the dieticians, whose section was organized about a year ago to take over from the pharmacists the victualing and food administration of the scores of military hospitals now handled by the Public Health Service. All the members of the section, which is headed by Mrs. H. B. Corsette, are graduates of schools of household economics, and are thoroughly trained and experienced in all matters relating to dieting. When fully recruited, the personnel will be about two hundred.

The nurses' corps, headed by Miss Lucy Minnegerode, consists of nurses who have been highly trained in everyday hospital work and a large proportion of whom are specialists in particular lines, such as mental and nervous diseases and tuberculosis. The corps today numbers 1,400 and needs 300 more. All applicants must, however, be graduates of recognized training schools, and must be registered either in the state in which they live or in that in which they were graduated.

Another body of nurses, 165 in number, who work in clinics and miscellaneous health activities under the supervision of Miss Ann Doyle, specializes in venereal disease treatment.

"Private nurses are sometimes spoilt, sometimes put upon. Let her not allow spoiling to spoil her, and let her learn from being put upon not to put upon others."—Florence Nightingale.

COMMITTEE ON FORMS AND RECORDS DISCUSSES THE ANNUAL REPORT*

TO PROVE of greatest value an annual report should at least serve the following purposes:

1. As a public record to the community of the institution's activities, both financial and professional.

2. As a permanent record to boards of trustees, auxiliary committees and other supporting bodies.

3. As a basis for allocating subsidies in communities operating under a Community Chest or similar subsidy plan.

4. As a public recognition of contributions or donations.

5. As a permanent record and public acknowledgment of the service of various professional men and women connected with the hospital.

6. To convey to the medical profession in general, information concerning professional services rendered.

7. To convey information to other allied groups, such as nurses, social workers, dietitians, etc., concerning such hospital activities, as are of interest to them.

8. To convey information to the hospital and public health fields concerning the activities of the hospital and for purposes of comparison.

A review of a large number of annual reports prompted the suggestion that if they are to serve their purpose of publicity, more attention be paid to their compilation to improve their attractiveness and promote their appeal. The following points are worthy of careful consideration: Size of page, individuality of cover, typography, arrangement of contents, and the liberal use of illustrations, showing various activities.

Dr. A. C. Bachmeyer's committee on forms and records presented a second report.

Although it is impossible for the committee to submit a standard annual report that will serve every hospital or community it desires to submit an outline that includes information of prime importance. This outline is not all-inclusive and can readily be amplified to meet the needs of individual institutions without sacrificing any essential details.

Outline of Annual Report

1. Table of contents.

2. Names of board of trustees, officers, committees, auxiliary groups, etc.

3. List of attending medical staff, designating rank and service.

4. Acknowledgment of gifts (form and type, as determined by the board of trustees).

5. Report of president of board of trustees.

6. Report of treasurer.

Corporation accounts. (Show present and part year figures for purposes of comparison.

Statement A.—Assets and liabilities, showing all capital holdings, investments, etc.

Statement B.—Income and expenses.

Operating accounts.

Statement A.—Income (compare two years). Show in detail, as follows, according to Scheme 1 or Scheme 2 of the American Hospital Association standard chart of accounts.

Statement B.—Expenses. Show distribution of expenses (compare two years) in detail as follows, according to American Hospital Association standard chart of accounts.

Statement C.—Resume of operating accounts (compare two years):
Total income.
Total expense.
Surplus or deficit.

7. Report of administrative officer:

The first part of this section should contain tables pertaining to certain vital statistics and the remainder should consist of detailed reports concerning the activities of the various departments of the hospital, such as nursing, social service, dietary, pharmacy, laboratory and the domestic and mechanical departments.

8. Statistical tables (compare two years).

Table A.—Service rendered:
Census (last day, previous year); patients admitted; births; total patients treated; patients discharged; deaths; census (last day, present year); patient days' care; normal; maximum census (date); minimum census (date); average daily census; average patient stay in hospital; number deaths within 48 hours; number deaths (institutional); mortality rate (excluding 48 hours deaths); autopsies (number); operations (number of major and minor); total hospital operating expenses; per diem capita cost.
Out-patient department: Number of visits; number of new patients; total out-patient department operating expenses; average cost per visit.

Table B.—Financial classification of service (compare two years). Admissions and patient days of: Pay patients, part-pay patients, free patients; totals.

Table C.—Patients denied admission (compare two years). Lack of accommodations; referred to non-staff physicians; communicable diseases; unsuitable (list causes); hospitalization unnecessary; totals.

Table D.—Analysis of service (compare two years). Medical, surgical, obstetric, specialties enumerated as to number of patients, days' care, per cent days' care.

Following the above statistical tables, various departmental report should be inserted.

9. Report of attending medical staff:

A. A brief review of the work of the attending staff, including lists of special studies made and articles published by the staff—clinical, laboratory and x-ray. In larger hospitals this section would probably be elaborated to show the various professional departments.

B. Professional statistics. The existing medical nomenclatures are not sufficiently comprehensive and are lacking in uniformity. Until a uniform nomenclature can be compiled through the collaboration of allied interests, the committee does not feel that any one of them can be recommended as a standard. Therefore, it does not recommend the publication at this time of professional statistics.

The committee believes that the use of standard tables of statistics, such as those suggested, the filing of such report with a central agency, such as the Hospital Library and Service Bureau, and the compilation of the accumulated statistics would make available a volume of accurate data concerning hospitals that would be of great value to the field.

Going in with your mind set on winning is the first essential to making a success in any work you may undertake. Half-hearted effort will not take you very far in any line of endeavor. If you think enough of a job to accept it, think enough of yourself to do your work the best you can and you will come out on top in the final count. Intelligent effort and close attention to business will win out in this or any other line, and the success of the best man in every organization is the final proof that leaves no room for argument.

Self-sacrifice is well enough but don't give yourself to be melted over for the tallow trade.—George Eliot.

*An abstract of the second report of the Committee on Forms and Records composed of A. C. Bachmeyer, M.D., F. E. Chapman and John F. Bresnahan, M.D.

THESE CHAIRMEN GAVE INFORMATION AND ADVICE ON THE EXPOSITION

They are: Dr. C. W. Munger (upper left) Dr. W. P. Morrill (upper right), Dr. S. S. Goldwater (center), Dr. H. W. Hersey (lower left), Dr. A. B. Denison (lower right).

NEWER TENDENCIES IN HOSPITAL CONSTRUCTION*

AMONG the helpful reports of the conference was that of the committee on buildings-construction, equipment and maintenance—which is given in full as follows:

The coupling of equipment with construction, and of maintenance with both, is perfectly logical. The mechanical equipment of a hospital building is inseparable from its construction, and notably affects the cost of construction. While the extensive use of mechanical equipment increases the cost of maintenance of the building, considered merely as a building, mechanical equipment, if intelligently chosen and properly installed, tends by simplifying and improving service to decrease the cost of administering the hospital. For this reason the original cost of serviceable equipment should not be regarded as a deterrent to its introduction.

The plans and specifications of a hospital represent a choice of means and may be said to be an expression of the opinion of the building committee, its technical adviser (superintendent or consultant, as the case may be) and the architect. In the planning of a hospital building as well as in the writing of the specifications experience should have a voice. The items which appear in the financial reports of hospitals under the head of "house and property expenses" and all other items of expenditure which are affected by the character of the hospital building and its equipment should be carefully and repeatedly analyzed by those who are engaged in hospital construction, for in this way only is it possible to arrive at an understanding of the ultimate or service value of the materials used.

This committee has been requested to speak of the "best policies," of the "consensus of opinion" and of "present standards" in the special field of construction.

Since planning logically precedes construction and is bound up with it, it cannot very well be ignored in this report, but the briefest mention only can be made of this phase. Among the standards, practices, and tendencies observed in current hospital planning, the following are deemed worthy of mention:

a. A growing disposition to inquire into the needs of a community before making plans, thus avoiding wasteful duplication and overlapping. The committee strongly endorses such inquiries.

b. A marked tendency toward concentration in planning, the object of which is to economize in the use of building materials, and to facilitate medical, administrative, nursing and domestic service.

c. The development of general plans through the putting together of the plans of individual departments, each conceived from the standpoint of precise needs; in other words, scientific, synthetic, technical planning rather than the adoption of loosely conceived general schemes, dominated by conceptions of architectural design. With the new point of view, architects generally are now in accord.

d. Theoretical emphasis on flexibility in anticipation of future expansion as well as of changing needs (with lapses in practice which, unfortunately, are all too frequent).

e. A widespread demand for convenient facilities for outdoor treatment. In practice there is observable a shifting of emphasis from roof to veranda as a means of outdoor treatment and the consequent lifting of the taboo on pitched roofs, which, while not universally approved, are reappearing in important multi-storied hospital buildings.

f. A demand for a reasonable measure of privacy for patients occupying semiprivate and ward beds, resulting in the subdivision of a considerable part of large open ward of former days into small wards, individual cubicles or even small individual rooms.

g. A more liberal use of plumbing fixtures, especially of individual watercloset in connection with private rooms, and of washbasins in both wards and private rooms. There is not, however, a proportionate increase in the number of private baths.

h. The use of single rooms in nurses' homes for both graduate and pupil nurses.

i. An increase in the allotment of space in nurses' homes for teaching purposes (lecture rooms, demonstration rooms, science laboratories, study rooms, libraries, etc.)

j. Efforts to obtain central and accessible locations for diagnostic laboratories and for treatment rooms of every description.

k. The reservation of considerable office space for social service and follow-up work.

l. Failure on the part of many medical staffs to urge the allotment of adequate space for out-patient work.

m. A diminishing use of small dumbwaiters for food service, large service elevators being required for the more modern types of heated or insulated food carriages.

n. The reconstruction of the whole question of centralized versus decentralized nursing service, experimenters being disposed to transfer a part of the fixed equipment of pantries, sink rooms, utility rooms and chart rooms, away from the traditional nursing station of the individual ward unit, and to locate this equipment centrally to the whole hospital. These measures are based on a theory of administration which involves the separation of nursing service into two parts, namely, actual bedside work, and the preparation of utensils, dressings, medicaments, and indeed of all materials and supplies which are used at the bedside or administered to the patient.

o. A feeling that serious efforts should be made toward the standardization of fixed equipment. Standardization is favored by the open-mindedness, the disposition to investigate or scientific curiosity, and the readiness to imitate, which may be said to be characteristic of the American mind. It is also favored by the growing recognition of hospital planning as a highly complex special art or discipline. Forces which impede or obstruct standardization are indefiniteness of purpose on the part of hospital boards, the employment of inexperienced hospital designers, the desire of hospital architects, superintendents, and consultants to achieve distinctive results, and strong commercial competition among manufacturers of building material and equipment.

Practices in Construction and Equipment

Turning now to construction and equipment proper, the following are noted as prevailing opinions, practices, or tendencies:

1. Insistence on fireproof construction, with or without legal compulsion.
2. Simplicity and economy in exterior design.
3. A certain hesitancy to use unmodified ferro-concrete construction on account of the dangers of excessive sound transmission.
4. The disappearance of the wood floor, and a lack of unanimity concerning the most satisfactory substitute for it (this subject is exhaustively dealt with in the report of another committee).
5. The occasional substitution of solid plaster for hollow tile in the construction of interior partitions.
6. The predominance of metal interior trim, which, however, is frequently omitted to reduce slightly the cost of construction.
7. The use in special interior locations of sound absorbing material and of soundproof doors.
8. An increasing demand for built-in features and specialties, such as specimen closets, drying closets, garbage closets, clothes chutes, fire hose cabinets, supply and instrument cabinets, etc.
9. The use of double hung sash in window construction and the constant improvement of devices for increasing the area of ventilation in summer and for facilitating window cleaning.
10. The substitution of interior or enclosed fire stairs for exterior fire escapes.
11. The omission of transoms over private room doors (cross ventilation being obtained by means of secondary dwarf or screen doors of light construction).
12. The use of brackets or wall supports in place of legs or floor supports for fixtures.
13. The installation of independent electric generating plants in nearly all except the smallest hospitals.
14. The more frequent use of petroleum as fuel.
15. Heating by direct radiation in preference to indirect.
16. Increasing use of refrigerating systems in hospitals of moderate size.
17. Attempts to eliminate overhead skylights for the natural light of operating rooms, and the substitution of enormous areas of vertical north lights.
18. The use of secondary emergency lighting (in addition to the standard electric lighting) for the artificial illumination of operating rooms.
19. The willingness of laboratory workers to accept artificial lighting for microscope work.
20. A preference for artificial illumination for colorimetric tests in chemical laboratories.
21. A demand for facilities for the examination of x-ray plates by daylight.
22. The use of portable vacuum cleaning machines in preference to pipe systems connected with high powered central machines.
23. The use of central destructors or incinerators for general waste disposal.
24. The use of local incinerators where the prompt destruction of infectious material is deemed important.
25. The use of a great variety of mechanical and electrical devices, such as call systems, telephone connections, the telautograph, radio connections, etc.
26. Emphasis on the direct ventilation of wards and patients' rooms, with the selective use of mechanical ventilation (especially exhaust ducts with fan equipment) for the ventilation of operating rooms, out-patient rooms, lecture rooms, kitchens, laundries, sink rooms and closets, toilets and baths, laboratories, autopsy rooms and animal rooms.
27. The widespread use of tiled wainscots for service rooms of all kinds.
28. The use of tile wall finish in receiving wards and, to some extent, in children's wards.
29. Insistence on the screening of all hospital buildings.
30. A recognition of the dangers inherent in the use of x-rays and the redoubling of preventive measures, such as the protection of wires and the special treatment of floors, walls and ceilings.
31. The introduction of warm colors for interior finish and decoration.

Seek the welfare of the human race.—Tarascon.

*Report of Committee on Buildings prepared by S. S. Goldwater, M.D., chairman; R. G. Broderick, M.D.; Frank E. Chapman; Pliny O. Clark; C. G. Parnall, M.D.; John M. Peters, M.D., and Wiley E. Woodbury, M.D.

REPORT OF COMMITTEE ON GAUZE RENOVATION AND STANDARD DRESSINGS*

THE report of the committee on gauze renovation and standard dressings is preliminary in nature; it is based not upon a large collection of observations, but on the experience of a small number of Cleveland hospitals. It is not a detailed recommendation of what *should* be done by all hospitals but rather an exposition of what *can* be done and the results that *can* be obtained. That these results are wholly desirable probably could be construed as a recommendation.

Reclamation of Gauze

In considering gauze reclamation the primary proposition to be taken up is its practicability in relation to other hospital activities. In other words, since the washing of gauze results naturally in more or less accumulation of the washed product, it must be determined that this gauze can be used in place of new gauze, that its use results in the saving of other materials more expensive, or that the washed gauze can be used more efficiently than some other material. The uses of washed gauze are really very extensive and should be developed to the highest degree possible without creating artificial demands or uses. It is the firm belief of the committee that a fair investigation of the merits of gauze renovation will show that it is practicable in a great majority of hospitals, if not in all.

The question of washing gauze is probably more difficult if the hospital executive does not have access to the experience of other hospitals. The figures compiled by one Cleveland hospital show that there was saved by washing gauze $500 per month. These figures represent very closely the experience of other hospitals that are washing gauze.

If it is found to be practicable and advisable to wash gauze, the next step is to determine the type of gauze to be used, in other words, the count of gauze that stands washing best. Rather extensive experiments were carried out by the committee to determine this point, the results of which are shown in an exhibit of washed gauze handled under a variety of conditions. The committee feels that its series of samples shows beyond a doubt that the higher counts of gauze stand the wear and tear of washing better than the low counts; and all things being equal, the higher counts are more desirable for reclamation purposes.

Before accepting this statement at its face value, however, every hospital contemplating the reclamation of gauze must determine one basic thing. It is obvious that there must be a balance between new gauze and washed gauze, insofar as its use is concerned. To be more explicit, a proper gauze balance is a point where the new gauze being put into circulation through various channels just supplies the normal decrease in the supply of washed gauze and no more. The committee's exhibit shows that the shrinkage of reclaimed gauze is a controllable thing, largely dependent upon the weight of the gauze used.

The committee's recommendation, then, as to weight of gauze is to use the lowest count gauze that will wash a sufficient number of times to preserve the balance between new and old gauze. Every effort should be made naturally to use washed gauze in the place of more expensive material but this use of reclaimed gauze should not be forced to the point of creating new demand or uses for gauze when some other material would be cheaper and more efficient. The committee recommends the use of 24-20.

The next logical step to be determined in considering the advisability of washing gauze is the method of reclaiming. This factor varies in detail in different hospitals since it is dependent upon so many personal factors; essentially most methods are the same. Very briefly, the process consists of soaking the gauze over night in cold water in a washer reserved for gauze washing. In the morning the gauze is washed in several changes of cold water, then several of hot water, bleached and dried in the centrifugal drier. Repeated bacterial tests have shown that the gauze is sterile at this point but usually, as a matter of extra precaution, it is run through the formaldehyde autoclave. It is then pulled out straight in the gauze room, wrapped in packages and sterilized again.

The committee took the standard specifications drawn up by the Cleveland Hospital Council as a basis for its investigation of standard dressings. Four basic sizes were decided upon by that council: 36x36, 36x18, 18x18, and 12x12.

One hospital in particular made a very careful study and analysis of the use of gauze with the following results: The consumption of new gauze for the year June 1921-22 was 124,400 yards. Of this amount, 115,255 yards went into the manufacture of dressings from basic sizes; or the dressing made from the four standard sizes of cut gauze utilized 92 per cent of the new gauze used by this hospital. These figures, while they are not based on the experience of many hospitals and hence can hardly be taken as the basis for a general statement, seem to the committee to be a convincing argument of the practicability of standardized dressings. It was further learned that in this hospital of the 115,000 yards of gauze used in the manufacture of standard dressings, 94,197 yards went into the manufacture of surgical sponges or about 76 per cent of the new gauze used. So since surgical sponges comprise such a large part of the dressing requirements, they were taken as typical of all the dressings and were studied more in detail.

But even if it is shown conclusively that it is practicable to use standardized dressings in all hospitals, just wherein lie the advantages to be secured by their use. In general, the answer to this perfectly natural question is that gauze manufacturers with all their mechanical equipment can perform certain mechanical processes more rapidly and consequently more cheaply than a hospital can do the same work by hand. The adoption of standard basic sizes is the first step toward enabling the manufacturers to set up the machine adjustments necessary for this. The ultimate result may be that manufacturers prepare these standard dressings and carry them in stock, but the committee does not stand ready to make any such recommendation at present. It has conducted certain preliminary studies, however, that are interesting as suggesting the possibilities in this direction.

The results of these studies seem to indicate that the machine cutter saves quite an appreciable amount of time over the method of cutting by hand, but the saving in time effected by the use of package-cut gauze is even more striking.

In concluding this report, the committee feels that inso-

*Read by A. B. Denison, M.D., chairman.

far as gauze renovation is concerned, it is practicable in the vast majority of cases, and the committee wishes to urge its careful consideration by every one responsible for the management of a hospital.

To turn to standardized dressings, the committee feels that the results obtained so far justify its belief that a widespread study of the possibilities of standardized dressings would result in an enormous saving to hospitals of the country and asks the cooperation of the association in compiling the necessary information.

COMMITTEE ON FOOD EQUIPMENT PRESENTS REPORT OF GENERAL INTEREST*

THE subject of the construction and proper operation of the dietary department of a hospital is such a vast one that a report of this sort cannot attempt to cover it.

The location of the kitchen is a matter which has often been debated, the three locations most used being: the ground floor or basement; the top floor of the hospital; a separate building. Each one of these locations has its advantages, and the committee holds no particular brief for any one type.

The architectural divisions into which the dietary department is separated can be roughly defined as a generality but the kitchen must by all means be designed to meet the requirements of the institution which it is to serve. Divisions which the committee would arbitrarily set for a hospital of 150 to 200 beds are as follows:

1. Main kitchen—36x40 ft.
2. Diet kitchen—23x27 ft., with dietitian's office adjoining, 10x12.
3. Dishwashing room—20x25 ft.
4. Ice storage and ice cream room—12x12 ft.
5. Large cold storage space in connection with general storeroom, but utilized mainly for foods for the dietary department, which can be requisitioned as needed—25x20 ft.
6. Three cold storage rooms opening into anteroom in direct connection with the kitchen—each 8x10 ft—with convenient shelves and hooks:
   1 for fruits and vegetables.
   1 for dairy products and eggs.
   1 for meats.
7. One small cold storage space about 2x4 ft. for sea foods.
8. One bread and pastry room about 10x15 ft.
9. Convenient elevators for transportation of food.
10. One diet kitchen—12x18 ft.—for each unit (20 to 35 patients).
11. One pupil nurses' dining room with serving room.
12. Three dining rooms for the various divisions of the staff (with serving room).
13. One dining room for male employes } with common serving room.
14. One dining room for female employes }
15. One dining room for patients' friends.
16. One milk room.

The committee has made no attempt to suggest grouping of these rooms, or arrangement in the rooms of the various devices which this report will bring to your attention. Those details must be determined separately for each hospital.

Labor Saving Devices Recommended

Labor saving devices permit the hospital to economize, both as to payroll and as to amount of foodstuffs used. It is the opinion of the committee that the following should be found in every hospital kitchen:

An electrically driven machine or machines which will chop meat and vegetables, and which may be used as a bread crumber.
A butter cutting device which makes it possible to use bulk butter rather than the more expensive print butter.
An electrically driven meat slicer.
An electrically driven bread slicer, with efficient safety devices.
An electrically driven vegetable parer.

Fireless cookers used overnight in the preparation of cooked cereals are economical and efficient.

It is advisable that as much cooking equipment as possible be heated by steam. Both copper and aluminum steam heated equipment have been found satisfactory. A recent innovation is a low temperature vapor cooker which is heated by means of steam but which does not employ live steam as a cooking agent. This new method would appear to merit consideration and further trial.

Coal gas is perhaps the most desirable fuel for use in preparing food which must be baked or roasted, or cooked on top of the stove.

A few years ago we seemed to hear more of the use of electricity for cooking than we now do. The use of electricity has been complained of as being slower and more expensive than gas. Improvements in manufacture will no doubt increase the speed of cooking, and the cost of electric power in the institution under consideration will no doubt determine whether the use of electricity is practical. An appliance which has come into quite general use within the past few years is the electrical bake oven for breads and pastries.

In localities where natural gas is plentiful it has been found admirable for kitchen use.

The gas, or other type of stove, should be of ample size. It should be properly located from the point of view of unnecessary steps and should have as few projecting surfaces as possible, so as to simplify the matter of cleanliness. The stoves, as well as all the heated equipment, should be grouped under one or more hoods which are connected with powerful ventilating fans for the purpose of carrying away heat and odors. Electric, gas, or steam coffee machines should be installed in a battery. There should be at least two urns in case of difficulty with one, and in most hospitals it is desirable to have three or more urns for coffee and one or more for tea and cocoa. In the majority of cases steam will be found most suitable for heating these urns.

Handling of Milk Important

The handling of milk, cream and ice cream in a hospital is a matter which requires earnest attention. The hospital executive who permits the use of old fashioned milk can and dipper for milk to be used for drinking purposes is probably making a grave error. Moreover, he is at fault if he does not periodically check the purity of the milk supply by means of bacteria counts made in the hospital laboratory. It is impossible for the committee to recommend any one method of caring for milk. Some hospitals may wish to purchase certified milk entirely for drinking. Others may prefer the pure raw milk and pasteurize it themselves, still others may purchase milk already pasteurized for general use. The committee, then, can only recommend that the dietitian and the superintendent of the hospital know and assure themselves of the purity of the milk when received by the hospital, and that they take every precaution to see that it is not further contaminated or neglected after it is received.

The electric mixing machine is indispensable in the modern institutional kitchen. It can perform so many services for the cook that she, perhaps, considers it her greatest boon.

There can be no doubt that the modern type of dishwasher is a vast improvement over hand washing. For

*Presented by C. W. Munger, M.D., chairman; F. R. Nuzum, M.D.; E. T. Olsen, M.D.; Miss Rena Eckman; C. S. Woods, M.D., and Miss Alice E. Thatcher.

hospital use, in the opinion of the committee, the automatic dishwasher which does not sterilize the dishes fails to perform a function which is most important.

Food conveyors are of many types. By some the steam table is preferred with containers sent up on the elevator and placed in the steam table on the ward. Still others use the food cart, heated by hot water or by electricity, or the newer type of food cart constructed on the principle of the fireless cooker or the vacuum thermos bottle. The conveyor heated with hot water has been criticized because of inefficiency and because of its greater weight which requires more current for the elevators. The electrically heated device has been said to overheat the food at times and to give it a warmed-over taste. The third type of food cart has been in use for a shorter period. Either for that reason or because it is superior, we have heard fewer criticisms of this type. It is surely true that it consumes no fuel, that it does not have the disadvantage of great weight, and it cannot overheat the food because the latter is kept at exactly the temperature at which it is put in.

Problems of the Diet Kitchen

The dietitian's kitchen, if conveniently located, need not duplicate all the equipment found in the main kitchen, although a certain amount of duplication is inevitable. The diet kitchen, as well as the main kitchen, should be conveniently located to the service elevators or dumb waiters which communicate with the various nursing units. If the food cart system is to be used these elevators should be so planned as to accommodate one or more of them.

Convenient to both kitchens we should place the cold storage rooms. These rooms should be well refrigerated, should be of ample size, but not so large as to be wasteful of the refrigerant, should contain convenient shelves, hooks or tables, and should be so constructed inside as to make absolute cleanliness easy.

The diet kitchen proper should contain such general cooking equipment as is necessary but should be particularly designed for the scientific preparation of special diet orders.

In order that the hospital diet kitchen may be most efficient, it is first of all important that there be a thorough understanding of dietetics on the part of the physician. A hospital is not prepared to render an efficient food service unless its dietetic department can, and does, teach dietetics to physician, and patient, as well as pupil nurses. The physical equipment of the kitchen must permit of the satisfactory preparation of both general and special diets economically, and there must be a transportation system that gets the food, warm and palatable, to the patient. There must be a plan of cooperation between the physician, dietitian, nurse, and patient so that orders given are accurately carried out and recorded.

In the preparation of special diets and especially of diets for diabetic, nephritic, hypertension, gout and obesity patients, it is well to have a section of the general kitchen set aside for this work.

The personnel of the dietary department is the most important consideration. The committee has not attempted to recommend any particular organism other than to insist that the chief dietitian control the entire food problem of the institution, and that she be not restricted merely to the preparation of special diets. Assistant dietitians should be provided if needed. The presence of pupil nurses and pupil dietitians in the department has a very desirable effect upon the standard of work, and stimulates the superior officers to set the best possible example. Efficiency of employes is all important. Salaries should be as generous as possible, and the department should be so managed that there is not the constant change in personnel so often seen.

The committee recommends a detailed accurate accounting system for the dietary as well as other departments. The dietitian must be able to analyze cost figures if she is intelligently to eliminate carelessness and waste.

WHY GAUZE RENOVATION PAYS

In the following table, comparable steps in gauze use are indicated and balanced where an equality exists. This table constituted one of the valuable supplements to the report of Dr. A. B. Denison's committee on gauze renovation and standard dressings which were being distributed from the exposition committees' booth.

NEW GAUZE

1. Delivered to gauze room or operating room from store room.
2. Opened, laid out and cut into sizes for dressings.
3. Made into Dressings.
4. Made into packages, counted and stacked.
5. Wrapped and marked.
6. Sterilized.
7. Delivered to Wards.
8. Used as dressings.
9. Collected.
10. Delivered to incinerator.
11. Burned.
12.

WASHED.

1A. Delivered to gauze room from Laundry.
2A. Pulled.
3A. Made into Dressings.
4A. Made into packages, counted and stacked.
5A. Wrapped and marked.
6A. Sterilized.
7A. Delivered to Wards.
8A. Used as dressings.
9A. Collected.
10A. Delivered to incinerator.
11A. Washed.
12A. Autoclaved.

Balance against No. 2.

It is noted that No. 2A is greater than No. 2, so we have considered No. 2 in comparison with 12A. All items then are balanced except 2A (Pulled). This item then must be considered in comparison with the cost of new gauze to take the place of the washed gauze used.

The figures indicating this relation in one hospital, are:

Gauze used .....115,255 yards new,
772,655 yards washed.

Total .....887,910 yards.

Cost When Renovated

New gauze,
115,255 yards @ .032 .....$3,668.16
Labor in gauze room, ... 3,900.00

Total cost $7,588.16
Saving by washing gauze $17,852.50

Cost When Not Renovated

New Gauze,
887,910 yards @ .0285 .....$25,440.66

"What is it to feel a *calling* for anything? Is it not to do your work in it to satisfy your own high idea of what is the *right*, the *best*, and not because you will be 'found out' if you don't do it?"—Florence Nightingale.

COMMITTEE URGES STANDARDIZATION OF CLINICAL AND SCIENTIFIC EQUIPMENT AND SUPPLIES*

IN THE preparation of a report such as this, embodying as it should a very general survey of the field of clinical and scientific equipment, one is faced first of all with one great outstanding fact, the multiplicity of similar types of equipment. It is almost impossible for every manufacturer to carry in stock an adequate supply of every item listed in his catalogue, and in most cases the equipment is made or assembled after the receipt of the order. In other words practically every large hospital order for equipment is "special work." This situation must be reflected in the price and in no way can it be credited to the manufacturer. Individual hospitals themselves are responsible for the large variety of similar types of hospital equipment and apparatus.

The remedy for this condition likewise lies within the grasp of the various individual hospitals through the medium of that much abused term "standardization." Of course, it must be admitted that standardization of equipment has its limits of practicability, and that this limit is sooner reached in scientific and clinical equipment than in almost any other general classification of hospital supplies. So keeping that fact in mind there certainly are basic standards that should be set for hospital equipment which would give the groundwork so essential in the selection of equipment.

It is the rather generally accepted plan for the hospital superintendent to familiarize himself to a certain extent with what other hospitals are using in the way of equipment and then to select the apparatus that most closely meets his need as he sees it. To do this without familiarizing himself with the background obtaining in every hospital he investigates cannot lead to the most intelligent buying of equipment. All inquiry as to equipment should include an inquiry into the factors composing the situation leading the purchase of such equipment. It is more valuable to know the essential features of the background of the equipment than to know that X hospital uses so many pieces, so large, of such and such an equipment.

The responsibility for the great variety of hospital equipment of similar nature which is on the market rests largely with the hospitals themselves and the responsibility for changing this situation also belongs to the hospitals.

The first requirement in the intelligent purchasing of hospital supplies is a thorough knowledge of the needs to be met by these samples.

Basic standards but not detailed specifications should be set up by some group competent to know, these standards to furnish the groundwork for considering the particular needs.

A knowledge of the "hospital composite" in other hospitals is more important in selecting equipment than the knowledge of merely what they have in the way of apparatus.

Lists of equipment submitted without any knowledge of the "hospital composite" are of very little value.

In purchasing surgical and laboratory supplies the superintendent must rely on his visiting staff for its judgment and must foster mutual confidence.

Since we feel that it is impossible to form an opinion intelligently as to the equipment needs of a hospital without of knowledge of background, we could not conscientiously prepare in advance any standardized lists of equipment for any hospital. Such lists have been prepared and are available—and probably serve as a very general guide in equipping a new hospital unit—but we doubt very much the desirability of including such lists in this report. A hospital is a composite of human beings trying to render humanitarian service to other human beings, and as such is not susceptible to rigid standardization in every particular any more than is the individual. The only way to judge the needs and the means of meeting those needs is by careful painstaking study in the light of all the background affecting those needs. May we not call this background the "hospital composite?"

The procedure of the hospital executive in determining the character and quantity of purchases, after a complete adjudication of all contributing factors, is basicly sound and practicable. In the purchase of many items of scientific and clinical equipment, one of these factors of "the hospital composite" assumes a very great importance, the fact that in these items are many that are very highly specialized and subject to changes in technique in diagnosis and treatment. In the interests of harmony and efficiency the director or superintendent must be prepared to go to reasonable lengths in trying to satisfy his professional staff. It may perfectly well be true that there should be standardization of such items of equipment, but the first step must of necessity be the development of a harmony between the executive and the staff and a willingness on the part of both to consider the proposition on its merits. The very real economies that can be effected by a larger use of standardized instruments and equipment are obvious. Manufacturers of surgical equipment would certainly operate more efficiently, with the consequent price of reduction, if they were relieved of the necessity of carrying in stock or in patterns and special dies the enormous reserve they are forced to carry on account of the diversified demand for instruments.

*An abstract of the report of the Committee on Clinical and Scientific Equipment and Supplies presented at the twenty-fourth annual conference of the American Hospital Association by A. B. Denison, M.D., chairman.

Another complicating factor in the purchase of surgical supplies is the relative short period of usefulness of many special instruments and apparatus due to the rapid changing of technique or other similar factors. The hospital executive must be prepared to discard for this reason much apparatus and many instruments still mechanically perfect, and purchase many new things if his hospital is to be kept to the point of greatest efficiency. In order to do this intelligently there must be a close cooperation between him and his staff, based upon mutual confidence. The most modern clinical and scientific equipment is part of their professional knowledge. The hospital director must draw on this fund of information if he is to keep his equipment to the point of greatest efficiency.

When we turn from a consideration of the items of equipment that must ultimately be used by the professional groups to the items that form part of the permanent equipment of the hospital, the situation is radically different. Steel furniture, for example is susceptible to the most rigid specifications, as to methods of construction, size of material, and thickness of metal and finish. The fact that a hospital may care to have a distinctive type or style does not change this fact at all for these are features that are basic and should be observed in any furniture regardless of the type or style. A larger purchasing of standardized pieces will most surely result in a lowered cost with no change in quality due to quantity production, but it is up to the hospital man to determine the price he is willing to pay for a distinctive type.

As an example of what can be done in the way of detailed specifications for some of these items, may I refer to the specifications for wheeled equipment,† and the basic specifications for sterilizers that have been prepared for the Cleveland Hospital Council. These specifications are too detailed to outline here, but I may say that they specify to an exactness the construction of wheeled equipment. The purchase of any wheeled equipment on these specifications would almost guarantee the purchaser against apparatus defective in design or material.

†These specifications are published in the Department of Equipment and Operation on page 364 of this issue.

LAUNDRY COMMITTEE OFFERS PRACTICAL AID TO THE SMALL HOSPITAL*

THE four points to be considered in the installation and operation of a hospital plant are: personnel, location and equipment, supplies and processes. In the smallest plant, suited for hospitals of 50 to 75 beds, it will usually be found that with the janitor or engineer to run the washer and extractor and even the flat work ironer, one woman will be able to handle the laundry, with perhaps some part time help to do part of the hand ironing.

All who have had experience agree that the best location for the laundry is a separate building but as this is hardly feasible for the small hospital it is suggested that it be located close to or connected with the boiler room, thus making it possible for the engineer properly to supervise the machinery or to assist in its operation. Likewise the boiler room usually is sufficiently isolated from patients' rooms that this location will prevent noise, steam and odors becoming a cause for complaint. But wherever located the space must be sufficient in floor area to provide wide passage ways for the handling of baskets, ample ceiling height, ventilation and light.

The equipment can hardly be discussed in detail in this report; suffice it to say that a washer, an extractor and a flat work ironer are the basic units and can be secured in sizes to meet the requirements of hospitals as small as 23 beds. One of the first units to be added after these three is a press, as it is at least four times as efficient as hand-ironing on those articles to which the flatwork ironer is not suited. Unless a large amount of personal work is done very little hand ironing will be necessary. For such as is done there should be provided electric irons preferably two for each board. In the larger laundries many accessory machines will be of service.

Supplies Often Source of Trouble

The matter of supplies is the one to which least consideration is usually given and which at the same time is the source of much dissatisfaction. And the first and most important supply is water. The nearer we can get to the old rain barrel, the happier will be our lot. Most city water supplies are not only hard in their natural state but are chemically treated to make them fit for human consumption. The lime contained in them unites with the soaps to form an insoluble lime soap which permeates the thread and produces that harshness which makes the linen so disagreeable to the skin and at the same time makes the fabric brittle and very materially decreases the life of the linen, because after all the real wear and tear on linen is in the laundry and not in use. Hard water likewise wastes supplies. According to one authority for each degree of hardness there is a theoretical soap waste of 1.3 lbs. per thousand gallons.

SOAPS. Soaps are a chemical compound of an alkali with a fat, with glycerine as a by-product. For laundry purposes chip soap has held the field for some years and many reliable brands are on the market. But even the reliable brands vary widely in water content, running from twelve per cent up to twenty per cent and if adulterated even more. The water does no particular harm but the careful buyer will object to paying soap prices for it. In the more recently introduced powdered soaps the moisture occasionally runs as low as eight per cent. In any case it is well to test purchases for moisture occasionally which can be done by weighing out a given quantity, say ten pounds, drying for 24 hours in the dry-room or even in a warming oven or hot air sterilizer and re-weighing. The initial weight in ounces should then be divided into the difference between the weights before and after drying in ounces and the quotient will express the percentage of water. Care must be exercised to take the sample from the middle of a freshly opened barrel as the soap near the surface always loses some of its water by evaporation, and would thereby give a false result.

ALKALI. Contrary to general belief alkali has no detergent action and is used only on account of its power of increasing the detergent action of soap. The only alkali

*An abstract of the report of the Committee on Laundry and Laundry Supplies presented at the twenty-fourth annual conference of the American Hospital Association by W. P. Morrill, M.D., chairman.

generally used is sodium carbonate, though some hospitals recommend trisodium phosphate as a "break down" although its value is questioned and has not been demonstrated in laboratory tests, as one pound of soda ash is equivalent to four pounds of trisodium phosphate. Economy would suggest that it be not used until proved of value. There are, however, other reasons for the use of alkali. The presence of soda decreases the tendency to the formation of calcium soaps. Certain dirts on soiled linen contain acids which the alkali will neutralize and some greases contain free fatty acids which the alkali will convert into soap thus aiding the detergent process.

BLEACHES. Bleaching is either a process of oxidation or reduction. The almost universally used sodium hypochlorite or javelle water is undoubtedly the best and in hospital work is particularly useful on account of its bactericidal action, it being best described as an impure Dakin's solution, and the identical material with which Semmelweis eighty years ago laid the foundation of hand disinfection in obstetrics, reduced his death rate from puerperal fever by ninety per cent, won for himself a lunatic's cell, and for motherhood practical immunity from the scourge which in his day condemned every tenth mother. It is not necessary to use bleach on hospital linen in every laundering and when it is used it should be rather light, not over two quarts of javelle water to a standard washer with six inches of water in the wheel.

SOUR. There are two reasons for the use of a "sour" in the laundry process. First to neutralize the alkaline materials remaining from the preceding process and second to remove certain stains which respond to acid but not to alkali. The most satisfactory sour is acetic acid used in the proportion of three to five ounces to a standard washer with six inches of water. If there are iron stains in the fabrics the addition of oxalic acid in the following manner is recommended: dissolve one pound of oxalic acid crystals in one gallon of hot water; use equal parts of the oxalic acid solution and of fifty-six per cent acetic acid, two to two and one-half ounces of each to a standard washer load.

BLUING. Bluing is used to cover up the grays, a process which with softer water and more carefully controlled processes is gradually becoming less and less necessary. Blue are of two types, the insoluble which are simply an exceedingly fine insoluble powder like ultramarine or cobalt blue and act by simple deposition on the surface of the thread; and the more common soluble or aniline blues which are actually absorbed by the fabric. The aniline blues have from four to thirty-six times the bluing power of the insoluble blues and have the added advantage of being more easily adjusted to the required tint.

STARCH. There are two types of starch process in general use, the one known as the cold starch process being in rapidly growing favor by reason of the fact that it eliminates the starch cooker and also one extraction process. A satisfactory grade of corn starch for the purpose will be supplied by any reputable supply house. Specially prepared starches cost more, but results do not justify their use.

Standard Washing Processes

When the soiled linen is received in the laundry it should first be sorted according to the character of the fabric, size of pieces and character of soiling. The following list gives a fair idea of classification: bed linen, dining room linen, operating room linen, uniforms white, uniforms colored, shirts and waists, collars and cuffs, socks and stockings, underclothing, overalls, colored aprons. All blood-stained linen should be given a preliminary soak in luke-warm water not over 100 degrees, after which it may take the course of all white work.

The standard washing process is as follows:

(1) Five minutes, lukewarm, three inches of water in cylinder after goods are saturated.
(2) Fifteen minutes hot suds, three inches water, sufficient soap to make six inches of suds on top of water. If powdered soap is used add one part soda to the three parts dry soap if water is fairly soft, increase soda according to hardness of water.
(3) Repeat (2).
(4) Five minutes hot rinse, six inches of water.
(5) Repeat (4) adding two quarts javelle water.
(6) Five minutes hot rinse, six inches of water.
(7) Repeat (6).
(8) Warm water, six inches, add four ounces sour and run ten minutes. Blue 10 minutes.
(9) Cold water to cool goods five minutes. If cold starch process is used the starch may be added directly to this load and run at least five minutes after addition of starch.
(10) Extract.

In loading extractor care must be used that articles are not entangled, as entangling leads to tearing of goods. Also extractor must be evenly loaded so that as it runs there will be no vibration. Neglect of this precaution is not only injurious to the machinery but dangerous to the operator. Safety covers should always be used.

If water of good quality is used it is not always necessary to use bluing.

All flat work can be taken direct from extractor to flat work ironer and the same applies to such work as is ironed on the press.

Articles that require hand ironing, however, must be partly dried first. This may be done in the open air, in which case they will require dampening. However, if a small tumbler is available, they may be tumbled partly dry and can then be taken directly to the ironing boards.

A BUSINESS PROPOSITION

The average individual is little concerned with his own health until sickness overtakes him. It is then that he is apt to compare his feelings with those of previous days when his attention was not particularly attracted to his physical being. Sickness is the manifestation of poor functioning organs just as much so as the "knock" of a motor engine is a warning of an ill functioning cylinder. If it is not remedied more trouble will follow. This is also true with the human body, if proper treatment is not instituted. It is further true that a great deal of sickness is preventable, if proper precautions are taken, but a large number of individuals will not heed nature's warning and will put such thoughts out of their minds, only trusting that sooner or later they will "automatically" become normal and healthy. Now wouldn't it seem foolish to pursue the same policy with reference to an automobile? Suppose that the knock in the engine should be treated with the same amount of complacency, about how long would the engine last? Is it fair that more serious consideration is not given the human body? It needs attention just as the automobile or any other mechanical device, and needs it more urgently at times. When an automobile becomes useless another one can be purchased, but when the body becomes useless it cannot be replaced. Happiness depends on health. One may have riches, title, fame, influence or any other asset, but if he does not possess that one essential requisite, health, his liabilities will far exceed his assets. Quite a few people who have good health really do not appreciate it, nor do they make any particular effort to retain their greatest of all assets. If they retain it, it is more by good fortune, not by good management.

Two well-known Boston hospital superintendents, Dr. Washburn of Massachusetts General (left) and Dr. Howland of Peter Bent Brigham.

REPORT OF COMMITTEE ON GENERAL FURNISHINGS AND SUPPLIES*

TO MEET the demand for a hospital bed of rigid construction, firmly locked and capable of withstanding hard usage, with casters movable and sufficiently large to allow ready transportation of the bed from one part of the ward to another when desired, several satisfactory beds have gradually been constructed. These are now supplied with adjustable springs, modifications of and improvements on the gatch type of frame. Of these some are controlled by hand, others are adjusted by cranks or ratchets.

The tendency to finish the metal bed frames in various colors to correspond with the general color scheme of the room has been a gradual development.

The construction of private wards and rooms for private patients has created a demand for special room equipment, which is now being supplied by complete equipment in metal, including beds, cabinets, dressers, tables, wardrobes and other pieces. Monel metal has also become a close competitor with other metals in the construction of table tops.

Dr. Harold W. Hersey, chairman of the committee on furnishings and supplies.

Many superintendents have furnished their private rooms, at least in part, with wooden furniture, and it might be of interest another year if an effect was made to secure a few exhibits of high grade wooden furniture.

The average hospital mattress is subjected to unusual wear, and should be of hygienic construction, covered with durable material and capable of being sterilized. The comfort of the patient should also be considered. In the selection of the mattress, as in the selection of all other equipment, the better the grade purchased the longer it may be expected to serve. It is now generally conceded that curled South American horsehair comes the nearest to fulfilling the above requirements. On the other hand, very satisfactory reports have come from the users of other materials.

Pillows should be purchased with the same care as other supplies. Goose feathers are generally conceded to make the best pillows, and these should be covered with high grade ticking.

Until recently there have been but a few high grade casters on the market. In the selection of a caster several points should be considered. The wheel should be ample to permit free movement and the shank should be sufficiently strong to withstand the stress and strain to which it is subjected and to uphold the weight applied to it. The bearing should be ample to allow the caster to swivel readily. Rubber tires if used are very satisfactory when constructed in one piece, and ease of replacement is desirable. Several such casters are now on the market.

Supplies Should Be Standardized

The purchase of hospital sheetings, pillow cases, toweling, blankets, etc., requires careful study. Several of the exhibitors have urged the hospitals to make greater effort to standardize their supplies, in order that in requesting competing firms to submit bids, all may be judged on an equal basis.

Frequently a piece of cotton goods of apparently strong texture will be found to contain a filler. This may usually be detected by rubbing a piece of the cloth between the hands, when the filler will dust out leaving a much inferior surface.

It is well to adopt a uniform size in pillow cases, sheets and towels. Not only is this essential in order to obtain uniform bids from dealers, but also that the same sizes may be encountered throughout the institution. It is obvious that if a certain size is ample at one time the purchase of a larger size should be avoided.

Standardization of all equipment and supplies should be carried to the greatest practical degree. This may be accomplished by a careful study of the needs of the institution and the selection of the best articles to fill that need. The construction of special equipment entails additional expense, and delay in delivery. If on the other hand definite standards are established, the manufacturers can turn out a smaller variety of goods, the dealer may reduce the amount of his stock and the cost to the consumer is correspondingly lower.

It seems quite possible that the American Hospital Association will eventually believe it incumbent upon it to standardize many of the articles in hospital use.

*Prepared by Harold W. Hersey, M.D., chairman; Karl H. Van Norman, M.D.; L. H. Burlingham, M.D., committee on general furnishings and supplies.

CHILD HEALTH RAILROAD INTERESTS CONVENTION DELEGATES

A Trip to Healthland on the Child Health Railroad, an exhibit planned by the Atlantic County Committee of the New Jersey Tuberculosis League, was among the cleverest of the non-commercial exhibits. The trip on the Healthland Flyer was arranged through the Child Health Organization of America and seemed to attract with childish fascination staid hospital superintendents and other adults.

A miniature railroad, with dining and sleeping car accommodations, led up to Healthland. Daily service consisted of four trains: the Red Cheek Local, the Healthland Flyer, the Supper Express and the Shooting Star Limited.

Some points of interest on the road to Healthland were: Hot Soup Springs, Spinach Green, Baked Potato Hills, Play Meadows, Long Sleep Mountain, Orange Valley, East Toothbrush, Bathtubville, Bread and Butter Square, Egg Junction and Cocoa Crossing. From the car windows could be seen the products of the respective villages.

The exhibit was mounted on a large table and occupied the New Jersey Tuberculosis League booth.

It was in making education not only common to all, but in some sense compulsory on all, that the destiny of the free republic of America was practically settled.—Lowell.

EXPOSITION PROVES SURPASSING SUCCESS

THE exposition of equipment and supplies not only proved to be the outstanding feature of the twenty-fourth annual conference of the American Hospital Association, but excelled all similar exhibits of the past. Not only in point of number and extent of individual exhibits, but because of unusually favorable conditions and the keen interest on the part of convention visitors, this year's commercial exhibit resulted in greater returns to the exhibitor and in increased benefit to the convention visitors.

It would be difficult to point out any single contributing influence which resulted in the success of this year's exhibit. Young's Million Dollar Pier proved an ideal place for such a display; with windows on every side, with large roomy booths and spacious aisles, the exhibitor found opportunity to display his merchandise to the best advantage. The natural result was more complete exhibits of merchandise with greater attention paid to the comfort of the convention visitor.

Exhibits Draw Largest Crowds Ever

Whether it was due to the energizing value of fresh sea air or the fact that ample time had been provided for the study of the exposition, visiting hospital superintendents spent far more time in the various exhibits than hitherto and manifested a keen and constant interest in the various products throughout the entire session. While during some unusually interesting general session the booths seemed deserted, the general rule was to find a generous attendance scattered about the various spaces at all times of day and evening.

Credit must be given to those responsible for the planning of the 1922 exposition for the highly creditable display, and its success proves the soundness of the committee plan of organization and the systematic grouping of the various exhibits.

While interest attached to the reports of each of the five chairmen, the work of three of the special exposition committees was so comprehensive as to focus the interest of delegates during the entire session. The headquarters of these committees were thronged almost constantly with convention visitors interested in learning more of the subjects in which these committees specialized, to study the educational exhibit prepared by one of the committees or to secure the literature and bibliographies distributed by two of the other committees.

Committee Reports Suffer Delay

Through an unfortunate combination of circumstances, the reports of three of the exposition committees which were scheduled to be given at the general session of Tuesday morning, were not presented to the conference until nearly the end of the sessions Because of this fact much of the value of these reports in connection with the exposition was lost. It is safe to say that if these reports had been given according to the announced program even greater interest in the exhibits would have been evidenced by convention visitors. As it was, many delegates were unable to benefit from the special studies of these three committees to the extent that otherwise would have been possible.

One of the criticisms directed at the 1921 conference was an apparent lack of balance as regards the variety of products exhibited. The 1922 exposition marked a distinct improvement in this regard. Yet despite the wide variety of merchandise and products shown great improvement is still possible, and the further broadening of the commercial exhibits should be one of the aims of those in charge of future expositions.

In Exposition Hall on Young's Million Dollar Pier was held the greatest exhibit of hospital equipment and supplies on record.

The section devoted to building—construction, equipment and maintenance—presented only a limited range of products. When one considers the enormous variety of materials and equipment required in the construction and general equipment of a hospital the possibilities of this section of the exposition are obvious. It is likewise true that there is an ever increasing interest in building specialties, materials and building equipment on the part of the progressive superintendent. While the Atlantic City exhibit was perhaps more comprehensive than last year, the products shown in this section could not be called rep-

resentative. The lack of variety of products naturally handicapped the committee in charge of this section. Heating and ventilating equipment, lighting fixtures, doors, waste disposal devices, elevators and dumbwaiters are some of the lines in which superintendents are interested, but which were not shown.

Furnishings Exhibit Incomplete

General furnishings and supplies offered a fairly representative exhibit, as was the case last year. However, wood furniture was again conspicuously absent and no manufacturer or dealer presented a display of such furniture, although this item represents a considerable total in hospital equipment. Likewise there is an absence of specialized information applying to the purchase of such products. Rugs, draperies and miscellaneous housekeeping supplies also were lacking. Office furniture and filing devices are subjects of constant interest and in these too the exposition lacked. There was no exhibit of shelving, storage cabinets and wardrobes for use in the housekeeping and storeroom departments of the hospital, a branch of equipment in which there is increasing interest.

The exhibit of clinical and scientific equipment and supplies predominated in the exposition, as is perhaps to be expected. Displays this year, however, were unusually complete and a wider variety of products was shown. A specialized exhibit of laboratory equipment and supplies was lacking, despite the fact that laboratory equipment is one of the paramount questions of the day. Outside of this fact, however, very little criticism can be directed to this section of the exposition and the exhibits were unusually comprehensive, complete and attractive.

In some respects the exhibits devoted to foods and equipment for food service were disappointing. This does not apply to the individual exhibits, which were splendidly conceived, but rather to products which were not exhibited. There was but a single exhibit of general kitchen equipment and yet this is one of the most important divisions of hospital operation. Likewise there was no exhibit of chinaware and but a limited display of silverware. Specialized equipment, such as mixing machines, dishwashing installations and hot food service carriages, was well represented and the interest manifested in these exhibits emphasizes the desire on the part of hospital superintendents for more comprehensive displays of food service equipment.

Model Laundry Is Operated

The display of laundry equipment and supplies was superior to previous years. A complete laundry installation, in operation, was on display and the many hospital executives interested in this branch of their institution were able to gain considerable practical knowledge. A more complete exhibit undoubtedly would have been secured had it not been for conflicting convention dates preventing a number of prospective exhibitors from the hospital exposition. Water softening equipment and comprehensive marking and sorting systems were subjects that would have added interest to this section.

Looking down one of the long avenues of exhibits in Exposition Hall.

These general criticisms, however, should not be taken as detracting from the 1922 exposition. The variety and value of the exhibits this year were so far greater than previous years that suggestions for further improvement seem hardly necessary. Exhibitors and visitors were alike pleased with the results. Arrangement of the conference programs gave hospital executives ample time for a detailed and careful study of every exhibit and the thronged booths and the pleased expressions of exhibitors gave constant evidence of the satisfaction of all concerned.

Innovations On Display

The value of the exposition as a means for the introduction of new designs and devices is becoming more apparent each year. Among the innovations exhibited for the first time at the Atlantic City expositions were several types of adjustable beds, an invalid lifter, an attachment to a water sterilizer for the preparation of saline solution, a new egg boiler, a new electrically heated hot dressing carriage, several types of stretchers, an electric heater for use in connection with laundry marking and a number of other interesting devices. The keen interest of hospital superintendents in improvements in institutional equipment was evidenced by the number visiting various booths to inspect and study the latest innovations. Suggestions and criticisms received at these annual expositions are of undoubted value to the producer in perfecting new devices.

A notable feature of this year's exhibit was the effort

on the part of nearly every exhibitor to add to the comfort of his visitors. Nearly every booth contained chairs and settees permitting the comfortable study of products and opportunity for helpful conference. In fact several commercial spaces were used solely as reception and rest rooms.

A complete laundry installation was in actual operation at the exposition.

While the majority of exhibitors came to the exposition with little thought of immediate sales, yet results in that direction were most gratifying. Many of the firms announced that the actual business booked during the convention totaled larger than at any previous convention.

Naturally there always are some complaints on the part of exhibitors. This is to be expected, to a certain degree, because of lack of proper facilities and natural congestion. The charges for furniture rental, inadequate (or exorbitant) janitor service and insufficient lighting in some spaces were the principal sources of annoyance this year. Unfortunately some of the causes of complaint were due to faulty planning and it is hoped that arrangements in future years will overcome such objections.

HOW FUTURE EXPOSITIONS CAN BE IMPROVED

The 1922 exposition plainly demonstrated the fact that the American Hospital Association has outgrown hotel conventions; that given proper planning and facilities an exposition of sufficient size can be developed to warrant the use of suitable public auditoriums as was done this year.

The interest manifested in the work of three special exposition committees which did the more intensive work offers complete justification for this plan of exposition development as tried this year.

It would seem logical, that in planning the 1923 exposition a similar form of committee organization be followed, dividing the exhibits in the same five general groups that were employed this year. A further step can well be taken by the inclusion of commercial representatives in the make-up of these five special committees, thus securing for the association more active cooperation of exhibitors in the planning and conduct of the exposition. For instance, instead of having five committees consisting solely of hospital superintendents, a general exposition committee might well be formed that would consist of the executive secretary of the association, a hospital superintendent as chairman of each of the five divisions and likewise a representative of commercial interest for each of the five general groups. This would result in a general exposition committee of eleven members, on whom would devolve the responsibility of the general planning of the exposition, the securing of proper facilities for visitors and exhibitors alike and the establishment of general rules of conduct to apply to the exposition.

With such an organization appointed within the next sixty days, plans could well be laid for making the 1923 exposition of even greater value than this year. The inclusion of commercial representatives would bring to the association the expert knowledge and experience of these men and insure a degree of cooperation on the part of exhibitors that would be of outstanding benefit. Likewise for the exhibitors such a plan should insure relief from petty annoyances and lack of proper facilities that so frequently mar the conduct of an exposition of this kind.

HOSPITAL EXHIBITORS ORGANIZE

Believing that the active cooperation of interested commercial firms would be of great assistance in the conduct of future hospital expositions, a permanent organization was formed at Atlantic City which is known as the Hospital Exhibitors Association. The express purpose of this association is to cooperate with the executives of the American Hospital Association so as to develop future expositions that will be of greater educational value to hospitals and allied institutions.

An executive committee was appointed to confer and act with the American Hospital Association in the development of the 1923 exposition. This committee consists of B. A. Watson, Crescent Washing Machine Company, chairman; Edward Johnson, Meinecke & Company, secretary; J. E. Hall, American Sterilizer Co.; L. C. Walker, Baker Linen Co.; Paul Esselborn, Century Machine Company; Henry L. Kaufman, Henry L. Kaufman Company; J. M. Myers, MacMillan Company.

The practical experience and progressive ideas of these representatives of well known commercial firms should be of great value to the American Hospital Association in the general planning and detailed arrangements of future expositions. The new association is direct evidence of the desire of mercantile firms dealing with hospitals to assist to their utmost in developing the educational possibilities of the annual exhibit.

Dr. Anker of St. Paul, president of the association at its former convention in Atlantic City, and his friend, Dr. Olson of Englewood Hospital, Chicago.

NEW YORK AND PHILADELPHIA HAVE OPEN HOUSE

FOLLOWING the close of the convention Thursday afternoon a number of the delegates entrained for New York and Philadelphia where they spent Friday and Saturday visiting hospitals and witnessing various demonstrations.

The hospitals in New York which were open or inspection included the following:

Bellevue, Woman's, Mount Sinai, Fifth Avenue, St. Vincent's St. Luke's, Beth Israel, Brooklyn, Long Island College, King's County, Metropolitan, City, Harlem, Fordham, Gouverneur, Sea View, Willard Parker and Kingston Avenue.

A few of the delegates took advantage of a boat trip around Manhattan Island, starting from the foot of East 22nd Street at 10:30 a. m. The boat stopped at Welfare Island which gave opportunity for a brief visit to the workhouse and penitentiary, and at Ricker's Island where the New York Hospital for the Care and Treatment of Drug Addicts was visited. At Hart's Island they visited the branch penitentiary and trade schools. Here luncheon was served, after which the trip around the Island was completed. In the afternoon there was a special excursion to Welfare Island where members of the social service department of Metropolitan Hospital escorted delegates on visits to the New York City Hospital, the Metropolitan Hospital and the Central Urological Hospital. At 4 p. m. tea was served in the nurses' home of the Metropolitan Hospital, after which delegates returned to the Women's City Club.

Those who visited the Woman's Hospital in the State of New York had an opportunity to inspect the telegraphone. After each operation the surgeon dictates his description into this instrument which transmits the dictation to a special stenographer's room.

A number of the delegates were especially interested in the new Fifth Avenue Hospital, with its single room service. Three floors of this hospital are now in active service and the institution was formally open on Thursday, September 28. Many also visited the new buildings at Mount Sinai Hospital, including the private pavilion, children's hospital and the auditorium.

St. Luke's Hospital was especially interested in showing its very complete x-ray department and its children's cardiac clinic. At the hospitals of the department of health there was opportunity to study the construction, arrangement and management of hospitals for the care and treatment of contagious diseases.

Thirteen Philadelphia hospitals were scheduled for inspection, and although not many delegates accepted the hospitality of the Hospital Association of Philadelphia those who looked in upon some of the hospitals of that city found themselves amply rewarded for their visit.

Some features which caught the attention of superintendents at the various Philadelphia institutions were:

The recordkeeping system, laboratories, x-ray department and large out-patient department at Episcopal Hospital, an institution of 520 beds.

A private pavilion, new nurses' home and small maternity building at Germantown Dispensary and Hospital, of interest to persons contemplating the construction of separate hospital buildings.

Hahnemann Hospital's social service department and its system of food service for private patients.

The food service from the private floor diet kitchen and the storeroom system at Jefferson hospital.

Plans for a $15,000 nurses' dining room at Jewish Hospital.

Lankenau Hospital's elaborately functioning follow-up system, and its effective way of manufacturing soap from waste fats by cold process methods.

The cafeteria service for nurses, a new five-story building in process of construction, and the circular wards at Methodist Episcopal Hospital.

Modern construction at Misericorida Hospital, an institution of 300 beds with several new buildings.

The extensive rebuilding program at Philadelphia General Hospital with its accommodations for 2,000 patients. Interest was displayed in the radium emanation rooms and work shops, the new nurses' home and various well developed out-patient clinics.

Reclamation of gauze at Pennsylvania Hospital; also its complete social service department.

Special demonstration clinics at Presbyterian Hospital on Friday afternoon and evening; among them a cardiac clinic, a prenatal clinic, and a children's clinic. Also new dietetic and bacteriological laboratories.

St. Agnes Hospital's new nurses' home and recently remodeled dispensaries, x-ray laboratories and operating rooms.

The complete and up-to-the-minute surgical pavilion at the University of Pennsylvania Hospital.

"Nursing is an art which concerns every family in the world."—Florence Nightingale.

(Underwood & Underwood)

New York's skyline and water front.

AMERICAN ASSOCIATION OF HOSPITAL WORKERS HOLDS PROFITABLE MEETING

THE semi-annual meeting of the American Association of Hospital Social Workers held September 26-28 was well attended. At the opening session the program included two main topics—community responsibilities of the hospital and social elements in medical training.

Miss Frances Stern, food clinician at the Boston Dispensary, was the principal speaker on the first topic. She discussed the part played by the hospital in fitting citizens for home and industrial life, especially by teaching them how to live in such a way as to maintain and improve health. One of the most important elements in social as well as in physical life is food, and Miss Stern illustrated her talk by specific reference to the food clinic. She showed how the clinic meets the needs of individual patients and what it means to the community to have such a resource. The usual food distributing agencies are far from meeting the need for diet and dietary teaching adapted to the condition of individual patients. Such feeding and teaching can be correctly done only in connection with medical diagnosis and supervision.

Around the booth of the Service Bureau on Hospital Social Work, in charge of Miss Ida M. Cannon and Miss Lena R. Waters, there was ever a crowd. All hospital social workers in attendance registered at the booth and informal lectures were held there. An important ant part of this exhibit was its psychiatric section.

Mr. Frank E. Wing, director of the Boston Dispensary, in discussion brought out other aspects of the social responsibilities and relationships of the hospital and dispensary.

Miss Dorothy Ketcham, director of social work at the Hospital of the University of Michigan, was unable to be present in person, but sent a paper in which she summarized the results of a study of the teaching now being done in departments of social work. Of 300 departments only six are known to be contributing in a definite manner to the education of medical students. About fifteen are assisting in the training of nurses, by lecture courses, by practical work, or by a combination of the two. Miss Ketcham quoted a number of interesting opinions from hospital social workers and discussed the value of the contribution which might be made by hospital social workers to the social education of the physician.

Miss Ida M. Cannon emphasized the point that such contribution need not necessarily be in the form of actual teaching but that progress in the definition of medical social work might be even more important and that the medical profession would in time make use of any really valuable body of knowledge which might come from the practice and interpretation of social work.

The business meeting of the association was held on September 27 at the Chalfonte Hotel. The treasurer's report showed a small balance to date and a prospect of getting through the year on a narrow margin. Nevertheless the contributions from districts are putting the association on a surer financial basis than it has had heretofore.

The president reported the action of the executive committee in accepting the constitution and by-laws of the psychiatric section and those of the Minnesota district. A new department of social work is in process of formation in Queen's Hospital, Honolulu. This association has been consulted as to its plans, and has been interested in this extension of the work.

Plans for the association's work in the coming year were discussed. They include the carrying out of committee work and programs in all the districts, publishing of pamphlets by the association (these in response to many requests for special literature), appointment of programs and nominating committees one year in advance of annual and semi-annual meetings, and work by committees of the association in recruiting of students, preparation of an exhibit and other work connected with publicity and education.

At an informal conference of superintendents of small hospitals under the auspices of the service bureaus on hospital social work, it was voted to ask the American Association of Hospital Social Workers to appoint a committee to study, during the coming year, the problems and methods of social service in small hospitals and to report at the meeting of the American Hospital Association next year.

HOSPITAL LIBRARY AND SERVICE BUREAU EXHIBIT RECEIVES MANY CALLS

More than 2,500 inquiries for bibliographies and approximately 300 requests for package libraries were made at the booth of the Hospital Library and Service Bureau during the convention.

Three librarians were in constant conference throughout the day and evening, and every conceivable question relating to hospitals was put to them. Many superintendents, architects and other hospital workers visited the booth each day and some several times daily to look at the charts, floor plans of institutions and other informative material.

The exhibit of hospital plans presented by the library is the largest collection of these plans ever made, it is said. Blue prints of hospitals, sanatoriums, nurses' homes and allied institutions of all sizes and localities were represented. Accompanying this exhibit was the library's list of hospital architects.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION HAS ENTHUSIASTIC ANNUAL SESSION

THE sixth annual meeting of the American Occupational Therapy Association marked an important milestone both in the growth of the organization and in its affiliation with the American Hospital Association.

The first session opened Monday, September 25, at 2:30. Owing to illness Dr. Herbert J. Hall, president of the association, was unable to be present. In his absence Mrs. Carl Henry Davis, member of the board of management, called the meeting to order and requested Mr. T. B. Kidner to take the chair.

The Rev. William W. Blatchford gave the invocation and the deputy mayor, Mr. Nichols, the address of welcome. Mrs. Eleanor Clarke Slagle read the president's address, which Dr. Hall had sent to her.

In his presidential address Dr. Hall first called attention to some of the things which the association has done and which can be accomplished even more effectively in the future "if it continues to be an advisory body and not a dictatorial one, if it takes care to be widely representative, if it avoids sectional jealousies and cooperates perfectly with the state and other groups of workers."

"Our meetings have been criticized," he declared, "because we have had too many papers read and because not enough time has been allotted to individual and local society reports. It is from such reports that we can expect real enlightenment. Of the excellent addresses that have been given in the past it may be said that they have been, for the most part, too general in their scope, that from now on we should try to make our formal papers cover special phases of our work. The exhibitions of crafts work have shown variety and originality, yet they have been rather too much alike."

Dr. Hall commented upon the remarkable vitality of many of the local societies and said they should be encouraged in their independence, but the local societies should bring their achievements to the national organization for appraisal if they do not wish to become limited and provincial. He recommended some constitutional changes, among them the substitution of an augmented board of managers for the House of Delegates. This recommendation was carried out later in the convention.

Dr. Dunton thought a committee should be appointed to draft resolutions of sympathy for Dr. Hall in his illness and of thanks for his delightful address.

Mr. Louis J. Haas, director of occupations, Bloomingdale Hospital, White Plains, N. Y., read an excellent paper on observation of patients' reactions as the guide to further treatment.

Mr. Haas said: "When the new case has been introduced to the proper task, the carefully planned and controlled machinery of therapeutic occupations does not run smoothly. Experience shows the problem is not so simple as this. The planning of the treatment has only begun and must continue through the patient's stay in the hospital. Those applying various forms of occupational treatment must observe and record the patient's progress expressed in reactions. The records are read, carefully weighing the information contained. This guides and furthers treatment.

"Therefore it is essential that there exist some definite method of receiving and recording information concerning the new case of observing the patient's reaction to the treatment. All of this information is thus available to guide those who plan and present occupational treatment."

T. B. Kidner, new president of the American Occupational Therapy Association.

Mr. Haas stressed the value of record keeping, showing the method of receiving information, how recorded, records kept of observations and progress; instructor's weekly report, and the work-accomplished record.

Many factors are to be considered in planning treatment, he declared, such as examples of treatment adaptation as applied to the underactive case; the overactive case, changes in treatment to meet relapse, when no added precautions are required and when conditions demand precautions; changes to meet various degrees of coordination; and re-training for those who lack self-reliance.

Experiences in directing an occupational therapy association were related by Miss Idelle Kidder former director of the Missouri Occupational Therapy Association. The first work of this association was the organization of a committee composed of deans of schools of medicine, officers of the Council of National Defense, and representatives of a school of mechanical trades, an institute of fine arts, a junior league workshop, a group of specialists and a secretary. With this executive committee, the school was soon founded, the financing being done by the Junior League of National Defense. The school was at once placed upon a high plane. Some of the graduates were employed in a hospital at St. Louis and elsewhere. In order to understand mental cases, arrangements were made for pupils to have a probationary training in the Kankakee State Hospital. This is working satisfactorily.

Miss Kidder concluded that the chief points which have brought about success were the wisdom shown in: (1)

The plan for thorough and extensive work and adherence to it; (2) the effort to have a first-class school; (3) the fact that there was one organization equipped to standardize plans and furnish guidance to all institutions within a state where conditions and problems are more or less identical; (4) general publicity through the press; (5) the acceptance or recommendation for work of no untrained volunteers; (6) personal visits to institutions to learn what had been accomplished and offers to carry out plans in close cooperation.

This session was concluded by a paper from Dr. Frederic Brush, medical director of the Burke Foundation, White Plains, N. Y.

Should Not Resume Work too Soon

Dr. Brush based his report on the convalescent treatment of nearly 20,000 men and boys in a country institution for a period of seven years. His patients were at all times from moderately defective to persons of high ability. Almost every ailment in some form or condition was represented. Dr. Brush used occupational therapy in the broad sense of including play and recreation in work about the grounds and institution. He valued especially activity out of doors. As the strength of the patients returned they were graded up to a period of from three to five hours' occupation. From this they passed frequently into a full day's employment about the institution while still under surgical dressing or other convalescent care. The final phase in his plan was return to old or better adapted wages, work or environment.

He suggested three age groupings, those under 15, from 15 to 50, and from 50 on. Those under 15 years gain in close contact with their elders and in group work. The middle age group adapts itself to leadership. As they press forward two difficulties appear: To restrain them safely in the earlier stages, and then to hold them long enough in gradual upbuilding. Most men want to go back to the job and social strain too soon. The older group are best adapted to policeing, gardening, care of the grounds and routine shop work.

Sales of the men's occupational products amount to not more than $1,000 per year, which shows how this work cure is given mainly to keep the patient in tone and spirit as well as in good physical condition. The real question is what most of the men make and do in after life because of this extra training.

Dr. Brush said that he was inclining to fewer crafts and shops and more to general upkeep and outdoor construction work, with few supervisors and more patient leadership.

Office Work Is on Increase

On Tuesday morning a business meeting was held of which the most interesting feature probably was a report of the secretary-treasurer, which could be divided into office work and field work. The former included replies to many inquiries regarding the inauguration or developments of occupational therapy in hospitals, advice on building equipment and material and on the engagement of personnel. The proof that occupational therapy is not very widely known was shown in numerous inquiries as to its nature and scope. It is of interest to know that it is planned to use this therapy measure at the New Haven Hospital where Yale medical students will receive their training. A conference was held with Dr. McQueck, who is preparing a thesis for his degree at the Oxford University, on occupational therapy of dementia praecox cases. Dr. Askano of Japan, the industrial rehabilitation officer of an important manufacturing organization in Tokyo, also sought advice upon what he termed the important first steps in rehabilitation. Officials of five states were advised regarding civil service requirements in their respective states.

On account of the increase in office work it has been necessary to engage office room in New York and to secure the part-time services of a clerk. On this account the expenses of the society must necessarily be heavier during the ensuing year and an increase in membership is desirable, the report brought out. Fifty so-called dead applications, that is, individuals who had not completed the necessary formalities, chiefly that of paying dues, which were made at the end of the last year, have been reduced to four. Eight members have resigned; one has died. The total membership now numbers slightly over 500.

The secretary-treasurer's work in the field consisted of visits to institutions and addresses to the public, to clubs and associations. At a meeting of the state board of control of Minnesota a whole day was given over to addresses by the secretary-treasurer and by Miss Bess Sutton, a member. Visits were paid the Veterans' Bureau Hospital at St. Paul, the state hospital at Rochester, Minn., and to the Mayo Clinic. In Milwaukee a number of meetings and conferences were held. A meeting of occupational therapy in Chicago was attended; also several hospitals were visited. An important conference was held at the national sanatorium, where Marion Shanklin is director. Another conference was held with the board of managers of the National Soldiers' Home at Dayton. At a meeting in Washington ways and means by which courses in social industries and rehabilitation might be developed generally were considered. A number of addresses were given at branches of general federation of women's clubs and the annual meeting was attended at Chautauqua. Here a number of associations sent helpful exhibits.

The report of the committee on finance was as follows:

"The question of financing the American Occupational Therapy Association during 1922 was left to the discretion of the board of management and the chairman of a finance committee. Inasmuch as the funds derived from the dues of members were sufficient for the needs of the current year, it was thought best not to institute a campaign for additional funds until business should improve.

"The report of the secretary-treasurer for 1922 makes it evident however that additional clerical help will be necessary if the business of the American Occupational Therapy Association is to be carried on without undue sacrifice by the board of management and officers and it is therefore cordially recommended that the association underwrite and support the very modest budget of $2,000 presented by the secretary-treasurer for 1923."

Mr. Kidner then made the report for the committee on research and efficiency, stating that but little work had been done by his committee, due largely to a trip abroad which he took in connection with work for the tuberculosis. He then proceeded to give some very interesting details of New York hospitals stating that we had but little to learn from the other side, where there is a great deal of good work going on in spots, especially in the several settlements for ex-service men.

Miss Ruth Wigglesworth then gave a report for the committee on teaching methods.

Dr. Dunton followed with a report on publicity and publications, giving some details on *Archives of Occupational Therapy* and analyzing the annual subscription list of which 38.8 per cent represents members of the society and other individuals; 20.5 per cent, mental or nervous

hospitals; 14 per cent, general hospitals; 13.5 per cent, libraries or universities. Attention was called to the rapidity with which the proceedings of the last meeting were published in comparison with those of former years.

Miss Susan C. Johnson read the report upon education in which she related that the gathering of data concerning salaries and hours upon which aides are employed and the existing conditions with regard to certificates, credentials, civil service requirements and other legislation which affects occupational therapy in the different states and the assembling of data which should set forth the true therapeutic value of occupation is progressing. The report was largely statistical, but included a number of reports of specific instances of recovery received from various hospitals as the result of her questionnaire.

House of Delegates Is Abolished

By a considerable majority it was voted to abolish the house of delegates and to increase the board of management to nine. At a later meeting the following were elected to the board of management:

Dr. B. W. Carr, Veterans Bureau, Washington, D. C.

Dr. Philip K. Brown, San Francisco, Cal.

Dr. James J. Mattison, Soldiers Home Management.

Dr. Frankwood E. Williams, National Committee for Mental Hygiene.

Miss Florence Fulton, of Philadelphia School of Occupational Therapy.

Miss Meta Rupp, of New York Society for Occupational Therapy.

Dr. Horatio Pollock, New York State Hospitals Commission.

On Tuesday afternoon Miss Winifred Brainerd of the Presbyterian Hospital, Chicago, opened an interesting discussion upon occupational therapy in general hospitals by her paper on the workshop in a general hospital. In this were considered the equipment, the crafts best adapted for use of those under instruction for a short period, and some of the advantages which had been observed to result from the use of the workshop. Here the patient usually feels that he is without restraint and by his contact with the aides he is ready to open up many channels of thought. He is inclined to air his pet grievances. He talks freely of the one whom he thinks has not been fair to him or complains that his tea was cold on a certain occasion. While these things are trivial, to the abnormal mind of the patient they loom up as mountains and culminate in a mental attitude which does not speed recovery. By telling them a patient gets relief and they do not bother him. In the workshop the patient is also given many opportunities to do little tasks which cannot be done upon the ward.

Miss Elsie Hassenstein of Cook County Hospital, Chicago, then described work upon the wards, its advantages and difficulties. She emphasized the importance of keeping up the interest of the physician in the patient's work so that he will act as a personal stimulant, and of making staff physicians responsible for the work of the patients.

A round table upon recreations followed; it was opened by a paper upon music as a means of mental discipline by Mr. van de Wall, musical director of the New York State Hospital Commission.

Mr. van de Wall's address was punctuated by many witty remarks which lent considerable emphasis to the points which he wished brought out. He quoted Dr. Soseman, who stated that any program of mental hygiene has to satisfy four demands: first, research for the descriptive element; second, the influence of these elements on the etiology of these diseases; third, the elimination of these influences; fourth, the power of resistance of the threatened individual. He stated that music as a means of enforcing mental discipline is a subject primarily concerned with the last item.

van de Wall Tells Benefits of Music

In conclusion he stated that music is, in the struggle for the restoration and maintenance of mental, individual and group discipline, of practical efficient help, and constitutes an essential factor in the therapeutic program of every sanatorium or hospital. He was followed by Miss E. M. Huseby, who asserted that the value of exercise as a remedial measure cannot be overestimated, but of primary importance is correct posture. Among mental cases there is a great deal of tension which may be overcome by utter relaxation.

Mrs. Eva Eskridge Harrington then read a paper upon games and dramatics, in which she first discussed the interesting question of the place of play in adult life. She detailed her work at Bloomingdale Hospital. In conclusion Mrs. Harrington said that in all recreational activities it is possible to get very close to the patient, but in order to do this it is necessary to play together as equals, not as a well person and a sick one.

On Wednesday morning reports of the occupational activity in the various states were given by individuals

Delegates to the American Occupational Therapy Association grouped on Young's Pier. In

who are actively concerned in directing such, this formed a most interesting feature, of which space permits mention only.

In the afternoon the very important question of the financial side of occupational therapy was taken up by Dr. Horatio W. Pollock, statistician of the New York State Hospitals Commission. He stated that there are two distinct aspects of the question of occupational therapy. First, as a department of medicine; second, as an industrial undertaking. From either of these standpoints it is worthy of support and funds should be provided for it. It, however, is necessary that its value be demonstrated clearly to the general public before adequate financial support will be granted. Proper facilities should be provided including a building to serve as a center. Some suitable activity should be provided for every class of patient. In many of our state hospitals, a revolving fund has been created by the generosity of private individuals, which is used for the purchase of supplies and which is augmented by the sale of the work of patients. Such is not adequate for large hospitals. He believed that aides should have no part in the financial management. Definite records of all work done should be kept.

Haas Gives Per Capita Costs

He was followed by Mr. Louis J. Haas, director of men's occupations at Bloomingdale Hospital, who gave financial details of the work and concluded with the statement that the per capita cost is about twenty cents per working day for men and about sixteen cents for women.

Dr. W. W. Richardson of the Mercer Sanatorium in his paper showed that the per capita cost per patient per month was about $4.50 or about 3½ per cent of the total cost of maintenance.

This was followed by a round table on training courses conducted by Miss Ruth Wigglesworth of the Boston School of Occupational Therapy. There was much discussion on this important subject, participated in by a considerable number.

On Thursday morning the first part of the session was devoted to reports of experiences in hospitals for ex-service men.

Miss Martha Emig opened the discussion upon general hospitals and was followed by Miss Dorothy Rouse. She in turn was followed by Miss Esther McComber who dealt chiefly upon the value which music had played in aiding convalescent men. Miss Willard stated that gardening was found to be the most valuable aid in her experiences.

Dr. Lloyd W. Ziegler opened the discussion upon neuro-psychiatric hospitals by a paper entitled "A Study in Occupational Therapy for Psycho-neurosis." This showed careful research upon the part of an author and is regarded as a distinct contribution to the literature of occupational therapy.

Miss Jeannette Moody then spoke of the craft work carried on under her direction at the Bronx Hospital.

Mr. C. C. Dunn of St. Elizabeth's Hospital emphasized the need of friendliness in contact with patients and regretted that there was not a better follow-up system in use.

Dr. B. W. Carr, chief of the physiotherapy and occupational therapy sub-section of the U. S. Veterans' Bureau read an excellent paper upon "Occupational Therapy in Tuberculosis Hospitals."

The remainder of the session was devoted to a round table on records, conducted by Dr. H. W. Pollock.

Mrs. Marshall Price of the Sheppard & Enoch Pratt Hospital described the records in use at that institution and was followed by Dr. Dunton of the same hospital who described the form used by him personally for the financial analysis of the costs of the occupational therapy department.

At the afternoon session a report of the activities in the National Soldiers' Homes was read by Miss Mary Shanklin, after which the reports from states were resumed.

T. B. Kidner Is New President

At the close of this session the new president, Mr. T. B. Kidner, was inducted into office. Mr. Kidner, an Englishman by birth, was for a long time a resident of Canada where he was connected with the Manitoba school system. Early in the war he entered the service of the Invalided Soldiers' Commission and continued this work for some time, eventually being loaned to the United States government when it entered the war. Since the war, he has been connected with the National Tuberculosis Association, as its institutional secretary. He is also one of the founders of the American Occupational Therapy Association.

As there was an urgent request on the part of many members that the sessions be hurried in order that there might be an opportunity to visit neighboring institutions, the round tables upon crafts best suited for the mental and nervous, and crafts best suited for the tuberculous, which had been scheduled to take place on Friday morn-

the background can be seen Hotel Tragmore and other buildings that border the Boardwalk.

Occupational therapists laid claim to the most attractive booth in Exposition Hall.

ing, were held Wednesday night. At both of these was considerable interest and discussion. The two round tables scheduled for Friday afternoon upon crafts best suited for bed cases and crafts best suited for the disabled were held on Thursday night. Here too, much interested was manifested.

The opinion of the majority was that this was one of the most successful meetings held by the association and it would appear that the short sessions, with the absence of the evening sessions, except in the two instances noted, were especially responsible for giving opportunity for personal contact. It was noteworthy that on the day following the first evening session members complained of greater fatigue.

Arrangements at the pier were most satisfactory except that in a few instances, notably when the meetings were held in the section hall, there were interruptions due to necessary household arrangements of the pier.

OCCUPATIONAL THERAPY EXHIBIT IS LARGEST EVER ASSEMBLED

Never has there been assembled so complete an exhibit of arts and crafts as was on display in the booths of the American Occupational Therapy Association.

Fifty-nine hospitals from various sections of the country contributed to the exhibit. Hospitals for the blind, hospitals for the crippled, tuberculosis sanatoriums, military institutions, mental hospitals and general hospitals had the handiwork of their patients on display.

Among the many arts and crafts represented were: weaving, basketry, carving, metal work, toy making, knitting, crocheting, furniture making, rug making (from rag to Navajo), printing, leather work, stenciling, copper work, etching, hand wrought silver work, jewelry making, pottery, lace making, batik work and many others.

Thousands of delegates and visitors on the Pier crowded the central booth, a spacious affair, and its adjacent overflow quarters at all times of day and evening. None of the objets d'art was for sale or the exhibit would soon have been carried away by purchasers, but orders were taken for duplicate articles and many persons left one or several.

In almost all cases the money taken in for articles sold goes to the individual patient, after the hospital has been reimbursed for the materials. A few of the institutions represented in the exhibit even provide the materials gratis. It is a practice common among a number of the hospitals to deduct from the sale price a charge of 10 per cent for waste, in addition to the cost of raw material.

Mrs. E. G. Shreve of Atlantic City was chairman of the committee on arrangements of the exhibit and with a staff of workers was kept constantly busy answering questions about the exhibit.

Several new crafts were being taught in the main booth and aides from many sections of the country gathered about to learn the latest.

In general attractiveness and appeal the occupational therapy exhibit easily dominated the entire exposition, both commercial and non-commercial displays.

A. H. A. RECOGNIZES MISSOURI AND PENNSYLVANIA ASSOCIATIONS

Recognition as a geographical section of the American Hospital Association was extended to the Missouri Hospital Association and the Hospital Association of Pennsylvania at the June meeting of the board of trustees of the national organization. Formal application of the Missouri association was signed by Dr. L. H. Burlingham as president. J. M. Smith, executive secretary, signed the application of the Hospital Association of Pennsylvania. The Pennsylvania Association was organized in December, 1921 and the Missouri association in February of this year.

PROTESTANT HOSPITAL WORKERS HOLD SECOND ANNUAL CONVENTION

CHURCH hospitals and problems peculiar thereto absorbed the attention of some seventy-five to 100 representatives of the Protestant Hospital Association in a three-day convention at Atlantic City terminating shortly before President George D. O'Hanlon called to order the twenty-fourth annual conference of the American Hospital Association. A program of addresses and round table exchanges constituted the second annual session of the Protestant organization. The smaller gathering with its opportunity for intimate and specialized discussion was regarded by delegates as of measureable benefit.

Dr. C. S. Woods Is New President

In the absence of President Pliny O. Clark, who it is understood has recently forsaken the hospital field, the convention was opened on Saturday afternoon, September 23, by Dr. C. S. Woods of Indianapolis, vice president. At the business session on Monday, Dr. Woods was unanimously elected president of the association for the coming year. The Rev. H. L. Fritschel of Milwaukee Hospital in Milwaukee, was named vice president with no dissenting votes, and the following members of the executive committee were chosen: for a three-year term, the Rev. James M. Long, Birmingham Baptist Hospital; James H. Mohorter, United Christian Missionary Society, St. Louis; and the Rev. C. O. Pederson, Norwegian Lutheran Hospital, Brooklyn; for a one-year period: the Rev. J. H. Bauernfeind, Evangelical Deaconess Hospital, Chicago.

Dr. C. S. Woods of Indianapolis will head the Protestant Hospital Association for the coming year.

To assist in obtaining an amendment or repeal of existing laws imposing taxes upon the legacies of hospitals, homes and other charitable organizations, the association took action by means of a resolution. The president will appoint a committee to cooperate with other committees and organizations to oppose such legislation. Another resolution adopted recommended the regulation by state and other legislative bodies of the sale and use of firearms, this from the angle of lessening the number of injury cases in hospitals.

Welcome to Atlantic City on behalf of its citizenry and clergy was extended to the delegates at the opening session by the Rev. H. More Blake, president of the Atlantic City Ministerial Union.

The secretary's report presented by Dr. Frank C. English showed a total membership in the association of approximately 200. The educational program of the past year has been among the ministers of the nation in an effort to quicken the sense of church people to the need of increased hospital facilities. A call has also been sent out through the churches for more student nurses.

In concluding his report, Dr. English declared: "It may be a little too early to announce that we are looking to a world program. Surely Christian America has responsibilities to the whole world. We need to train doctors and nurses with the spirit of sacrifice for our foreign hospitals, and we should not expect to escape the responsibility of providing healing for the afflicted throughout the world."

The church hospital from the triple viewpoints of its support, administration and vision formed a topic for three forceful papers at the first day's session; they were presented respectively by C. B. Hildreth, superintendent of St. Luke's Hospital, Cleveland; C. S. Pitcher, superintendent of Presbyterian Hospital, Philadelphia; and Dr. C. S. Woods of Indianapolis.

"A large proportion of both nurses and doctors are in the profession more because of the remuneration than the desire to administer to the needs and suffering of their fellow men," said Mr. Hildreth in his address. "Christian doctors should make up staffs of church hospitals and Christian nurses should compose the nursing groups." He urged the great need for additional hospital bed capacity. Dr. N. E. Davis of the Methodist Hospitals and Homes Association of Chicago led the discussion of the paper.

Issue with the report of the committee on training of hospital executives was taken by Mr. Pitcher in discussing the administrative aspects of a denominational hospital.

"The majority of students who have only the training outlined in this report," he asserted, "would be too young and inexperienced to grasp the situations with which they would have to cope in the administration of a hospital. Disciplinary training of the young, who have had no experience, is inadequate. I believe the old apprentice system, backed by experience, is preferable when supplemented by didactic instruction, through meetings of the hospital associations and special courses in universities and other suitable places. It is not within the scope of

human minds to accumulate the information a superintendent should possess through a short course of training. This can only be secured through years of experience in administrative work."

Mr. Pitcher also attacked the collateral inheritance tax imposed on charitable institutions. Discussion of his paper was led by Miss May A. Middleton of Philadelphia.

Some of the possibilities which lie in the path of the church hospitals were enumerated enthusiastically by Dr. C. S. Woods in an inspiring address on "The Vision of the Church Hospital."

From the standpoint of practical application, no single paper of the convention was of more value than the address on Saturday evening of Ralph Welles Keeler, director of publicity of the Methodist Hospitals and Homes Association, Chicago. Something of the mechanics of preparing copy for the press, of news values, of human interest material in the various hospital departments, and of the vitalizing of statistics and annual reports was contained in his address.

The Rev. Herman L. Fritschel concluded the first day's session with a well prepared paper on "The Relation of the Church to the Hospital."

Special Services Mark Sunday

On Sunday morning the Atlantic City churches, most of which are convenient to the hotels bordering the Boardwalk, opened their doors to the delegates. In many cases special sermons were delivered, stressing the value of denominational and interdenominational hospitals.

The Rev. N. E. Davis, D.D., of the Methodist Hospitals and Homes Association, Chicago, an expert on problems of hospital organization and administration, spoke before a large gathering on Sunday afternoon. The title of his address was "Essentials in Hospital Organization." A representative of the Southern Presbyterian Mission Board, Mrs. Martin, told of her work and of the need of doctors and nurses in Central Africa where the majority of deaths occur from preventable diseases and where seventy per cent of the infants are said to die because of the ignorance of parents in their proper care.

Monday morning brought the closing general session of the Protestant convention with its program of addresses, round table led by Dr. James R. Alexander of the Presbyterian Hospital, Charlotte, N. C., election of officers and transaction of general business.

"The Place of the Steward in the Hospital" was the topic assigned to the Rev. C. O. Pederson of Norwegian Lutheran Hospital, Brooklyn, and his remarks were of practical worth to the superintendents. He stressed the wisdom and economy of competitive buying, the need of a careful check on waste food and similar problems of efficient operation.

In the open discussion that followed Mr. Bauernfeind of Chicago called attention to the need of constant vigilance over the garbage can and other points of leakage. Miss Alice Thatcher of Christ Hospital, Cincinnati, outlined the duties of the housekeeper as she sees them. Dr. Alexander of Charlotte, N. C., emphasized the necessity of the superintendent himself knowing how to buy before he can train or judge a steward properly. At St. Luke's Hospital, Cleveland, said Superintendent Hildreth, requisitions for food supplies and all articles must of routine pass through the superintendent's office.

Moral Problems of Nursing Students

The paper prepared by Miss Maude Lucile Howell of Milwaukee on "The School for Nurses" was lost in transit, but her hastily sketched substitute was warmly received. It was a plea to training school superintendents to inculcate the ideals of their profession into the newest probationers and by educational and psychological methods to lead them constantly and steadily toward high standards of conduct.

Smoking, drinking, late hours, vulgarity—these were some of the charges brought by this non-sectarian hospital supervisor against the graduates of church training schools. Her accusations brought prompt rebuttal from various sources. Numerous suggestions for curbing tendencies toward irregularities of conduct were offered. Dr. Alexander and E. S. Gilmore saw the remedy in a careful choice of superintendents of nurses who can by percept and example guide the students into habits of refinement. C. W. Williams of Boston told of his hospital's careful entrance requirements which call for letters of recommendation from the pastor, physician and friends of the prospective student. Miss Pierce of Children's Hospital, Cincinnati, spoke a good word for alumnae registries, declaring that a private duty nurse who is recommended by an alumnae registry is sure to have high standards of conduct. Dr. B. A. Wilkes of the Missouri Baptist Sanatorium threw a bomb into the convention when he stated with some emphasis that hospital work is demoralizing to nurses. Only the gavel of the chairman, hastening the belated program, saved Dr. Wilkes from a concerted counter-attack.

In a brief discussion of the advantages and disadvantages of interdenominational hospitals, the ayes and the nays seemed to number equally. The Rev. Mr. Pederson sees in the interdenominational hospital the entire escape of institutions from church influence. Mr. Clarence H. Baum of Danville, Ill. thinks the interdenominational institution a worthy goal.

What Is Christian Medical School?

A question box brought out a variety of subjects, mostly touching the hospital in its ecclesiastical relations. A query on the establishment of Christian medical schools led to a short debate between Dr. Woods and the Rev. H. L. Fritschel. Dr. Woods sees the Christian hospital as any institution which is not Mohammedan, Buddhist, or some great non-Christian religious group. Most medical schools in this country are connected with universities, he declared, and they must surely be giving medical instruction in a Christian fashion. The Rev. H. L. Fritschel does not feel that he would like to subscribe to the particular philosophy of some medical professors in American universities.

A show of hands on the question of furnishing nurses' uniforms showed that half of the superintendents present followed that practice in their institutions. With but few exceptions, all give nurses some allowance in the way of money, uniforms or books.

A fair majority raised their hands in affirmation to the question of providing some religious instruction in their nursing curriculum. The keeping of records in their hospitals is largely in the hands of librarians, another question brought out. Opinion on the proper amount for the endowment of ward beds and private rooms brought answers ranging from $5,000 for ward beds and $10,000 for private rooms to $10,000 for ward beds and $20,000 for private rooms.

Mr. Pitcher found occasion through the round table discussion to tell of the apparent success of the Philadelphia experiment in a joint nurses' training course.

The next convention of the association will be held in conjunction with the American Hospital Association, the date and place to be fixed by the board of trustees.

LEADERS IN CALIFORNIA HOSPITAL BETTERMENT MOVEMENT MEET IN ANNUAL CONFERENCE

THE second annual convention of the hospitals of California was held under the auspices of the League for the Conservation of Public Health at the Maryland Hotel in Pasadena, September 5-8. The convention was most enthusiastic and was successful from whatever angle viewed. Over 300 hospitals were represented by more than 800 delegates and other representatives. Hospitals from all parts of the state and of every class and condition were included. The outstanding feature of the program was that there were no long papers; in fact, very few printed papers were read.

The convention hinged around the discussion of various important problems connected with hospitals. Certain experienced persons were invited to open the discussion of each subject with an address of ten minutes or less; other discussants were allowed four minutes. Every problem mentioned in the program was discussed fully.

In opening the convention the chairman, W. E. Musgrave, made the following statement:

In order that we may visualize the magnitude of the problems involved in the campaign of Hospital Betterment in California to which the League for the Conservation of Public Health is dedicated, let me present a few outstanding facts and figures which tell the story of hospital and health work in this state:

Totals of a few items of the annual cost of sickness and health to the people of California:

Maintenance of hospital beds	$ 60,000,000
Official public health	12,000,000
Laboratories, etc.	5,000,000
Nurses' fees and nurses' maintenance	5,000,000
Semi-trained nurses' fees	1,000,000
Hospital upkeep	10,000,000
Physicians' fees	15,000,000
Collected and expended by voluntary medical, health and medical welfare organizations	5,000,000
	$113,000,000

These conservative figures show that the people of California are annually contributing and paying in taxes over $28 for each man, woman and child for a few of the services of health."

Physicians Ample for Population

In regard to physicians there are for approximately 4,000,000 people in California:

8,000 physicians in the state.
7,000 of these are licensed to practice medicine.
About 5,000 are in active practice.
About 4,000 are members of the California Medical Society.
There is one physician in active practice to each 800 of population.
$3,000 is the estimated annual gross average income of physicians of the state.
$15,000,000 represents the aggregate annual gross income of all the physicians of the state.

The above statistics show that California has an adequate number of educated physicians. The number of physicians is increasing faster than the population.

Based upon the law of averages and available statistics, it is conservatively estimated that there are:

120,000 people ill all the time in California.
900,000 people are ill every year.

The expenses for physicians' fees for sick people, therefore, average $15+ per annum per person. This, of course, is but a minor fraction of the total cost of sickness. This does not include the more than $5,000,000 of free service rendered annually by the medical profession of the state."

As to nurses there are:

About 5,000 registered nurses in the state.
About 3,000 nurses are on duty with the public, exclusive of those on salaries in hospitals.
$1,500 is the estimated average annual income and maintenance of a nurse.
$5,000,000 represents the aggregate gross income and maintenance of the nurses of the state.
$100,000 represents the aggregate gross income of "practical nurses," etc.

Hospital and Sanatorium Statistics

There are 500 hospitals in the state, of all classes, kinds and conditions.
45,000 is the approximate number of hospital beds available for the sick.
35,000 is the approximate average number of hospital beds constantly occupied.
$4.50 is the average cost of maintaining a hospital bed for one day.
$160,000 is the estimated daily cost of maintaining all hospital beds of the state.
$60,000,000 represents the estimated aggregate annual cost of maintenance of all hospital beds of the state.
$5,000,000 represents the estimated cost of x-ray, laboratory fees, drugs, dressings, and other essentials of sickness, exclusive of those cared for in hospitals.
$10,000,000 represents estimate of the annual cost of upkeep for hospitals and sanitariums.
$160,000,000 represents the approximate amount invested in hospital buildings, equipment and real estate in California.
From $1,000,000 to $5,000,000 is invested annually in new hospitals and enlarging old ones in the state. This is a constantly increasing amount.
Exclusive of physicians, some 25,000 people are constantly employed in the hospitals alone in day and night service for the sick.
Over 90% of the hospitals are conducted at a financial sacrifice to their owners or supporters and to the medical profession that staffs them.

Twelve million dollars is a conservative estimate of the amount of money spent by state, county, municipal and other official health agencies in controlling disease.

Impressive as are the above figures of the costs of health to the people of California, many of the most expensive items incident to disease are not even mentioned. Some of these are:

The millions wasted by loss of earning time by patients, due to illness. If we consider that only 20,000 of the 120,000 people ill in the state all the time are earners and that they earn only an average of $5.00 a day, this item alone amounts to $37,000,000 a year for California.
The unknown millions spent for services of people, exclusive of physicians and nurses, whose earning time is lost in serving the sick.
Unknown millions spent for patent medicines, cure-alls and other self-prescribed treatments.
Unknown millions extracted by quacks, cultists and miscellaneous so-called doctors, healers, etc., of various species.
Unknown millions spent in visiting spas, mineral springs, health resorts and other sure-cures of disease and maintainers of health.
Millions spent in mineral waters, health water, freak foods, physical culture and various other combinations opposed to medicines.
Vast millions collected and spent by voluntary health organizations, legitimate and useful as well as illegitimate and vicious.

Condemn "Irregular Practice" Initiatives

A number of important resolutions were passed dealing with various problems confronting hospitals. Among the most important of these resolutions was one condemning the chiropractic, osteopathic and anti-vivisection initiatives, now before the people of California. Another was the unanimous endorsement and approval of the uniform clinical record system that has been prepared and endorsed by the Medical Society of California and issued by the League for the Conservation of Public Health. Another was the unanimous endorsement of the outline for "The Rating of Hospitals," published in part in the *Journal of the A. M. A.* of August 19, 1922, by Dr. W. E. Musgrave, and a recommendation that this outline be held as the ideal toward which all hospitals of California are working, and that the convention commend and endorse the work of the League in the Hospital Betterment Movement in California.

Other meetings held in connection with the convention were those of the Council of the Medical Society of California, a meeting of the League for Nursing Education, and a meeting of the Council of the State Society with the officers of all county societies of the state.

BRITISH COLUMBIA HOSPITALS ASSOCIATION MEETS AT NEW WESTMINSTER

THE annual convention of the British Columbia Hospitals Association was held at the Royal Columbian Hospital, New Westminster, B. C., August 29 to August 31. Attendance was good, more than thirty hospitals in various parts of the province having representatives present.

Mr. George McGregor, president of the board of directors, Provincial Royal Jubilee Hospital, Victoria, and first vice-president of the association occupied the chair in the absence of the president, Dr. H. C. Wrinch of Hazelton, who was unable to be present. He was greatly missed as was Dr. M. T. MacEachern, both having been identified with the association since its inception, and having contributed greatly to its success.

The meetings took place in one of the wards of the Royal Columbian Hospital transformed for the time being into an ideal auditorium. The corridors and adjacent rooms were alloted to the exhibitors, thus ensuring inspection of the exhibits by all who attended the sessions.

The opening session was devoted to the consideration of business administration and finance. Mr. George Haddon, managing secretary of the Vancouver General Hospital, presided, and gave an introductory address on hospital accounting under the government plan. This was followed by a thoughtful paper on "Auditing, Administration, and General Finance in Smaller Hospitals" by Mr. E. W. Carr Hilton, secretary of the King's Daughters Hospitals, Duncan, B. C. Mr. E. S. S. Withers, general manager of the Royal Columbian Hospital, spoke briefly on purchasing methods. Discussion was keen and very informative.

Part of the afternoon session was devoted to the consideration of nursing service, Miss K. W. Ellis, director of nursing of the Vancouver General Hospital, presiding. Miss Helen Randal, inspector of training schools for the British Columbia Graduate Nurses Association gave a resume of training school conditions in the province. Discussion was opened by Miss K. Stott, superintendent of nurses in the Royal Columbian Hospital. Marked interest was displayed, especially by members of boards of directors and it was apparent that conventions of this type when representatives are present from all departments of hospital activity provide an excellent opportunity for fostering mutual understanding and a spirit of cooperation.

Dr. George Drew, president of the Fraser Valley Medical Association, took charge of the conference on medical service which followed. Its main feature was an address by Dr. A. S. Monro of Vancouver on "The Patient as the Link of Cooperative Effort Between Hospital and Physician." At the evening meeting addresses of welcome were given by the mayor of New Westminister and by other representatives of public bodies. The provincial secretary, the Hon. J. D. MacLean, delivered an address in which he dealt with hospital problems in general with special reference to that of finance, outlining the plans of the provincial government in this connection. It was felt that the provincial government was in hearty accord with the hospital directorates of the province, and that certain measures would be taken that will ultimately prove of great assistance. Dr. T. R. Ponton, medical superintendent of the Vancouver General Hospital, spoke on standardization of hospitals, and the Rev. C. C. Owen delivered an inspiring address on "The Spirit of the Hospital."

On the succeeding day both morning and evening sessions were given up to the business affairs of the association The evening was devoted to the discussion of hospital economy from the standpoint of directors, physicians, nurses, and business managers. Mr. R. B. Leders, purchasing agent of the Vancouver General Hospital, gave an introductory address on hospital waste which provoked considerable discussion. Mr. J. J. Banfield, director of the Vancouver General Hospital, gave a witty speech on "Economy from the Director's Points of View," and Dr. W. B. Burnett of Vancouver gave a trenchant exposition of the physician's angle of the question. Miss Grace Kerr, superintendent of the Ladysmith General Hospital, brought out many practical points in her presentation of the nurse's point of view.

The morning session of the closing day of the convention was given over to the consideration of the problems associated with domestic management. Miss Ann MacArthur, superintendent of the Kootenay Lake General Hospital, presided and Miss M. Trood, chief dietition of the Vancouver General Hospital, delivered the introductory address. Discussion was opened by Mrs. M. P. Simpson, housekeeper of the Royal Columbian Hospital, who contributed some very practical and illuminating comment Dr. H. C. Steeves, superintendent of the Provincial Mental Hospitals, gave a most interesting description of the care of mental disease in British Columbia.

In the afternoon a conference on the organization and function of women's auxiliaries and other voluntary helpers took place. Mr. John Hanbury, president of the Women's Auxiliary of the Vancouver General Hospital, presided and delivered an introductory address. Discussion was opened by Mrs. A. W. Gray, president of the women's auxiliary of the Royal Columbian Hospital, New Westminister. Great interest was manifested in this session, and as a result, it was decided to admit duly authorized voluntary auxiliary bodies to corporate membership.

At the closing session an animated discussion took place concerning the disposition of moneys accruing to hospitals as the result of government liquor control. The present system of distribution was held to be unsatisfactory, and representations will be made to the government requesting certain changes.

The convention next year will meet at Penticton.

Officers of the ensuing year are: Dr. H. C. Wrinch, Hazelton, president; Mr. Charles Graham, Cumberland, first vice president; Mr. J. T. Robinson, Kamloops, second vice president; Mrs. M. E. Johnson, Vancouver, treasurer; and Miss Ethel Johns, Vancouver, secretary.

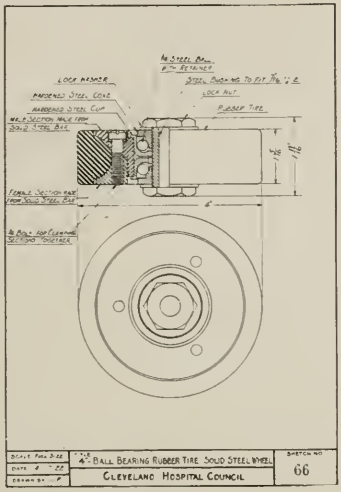
The members of the executive committee are the following:

Mr. R. A. Bethune, Kamloops; Miss Charlotte Black, Prince Rupert; Dr. P. Brown, Nanaimo; Rev. Father O'Boyle, Vancouver; Dr. M. T. MacEachern, Ottawa; Miss J. F. McKenzie, Victoria; Mr. George McGregor, Victoria; Miss Ann Mac Arthur, Nelson; Mr. E. S. Withers, New Westminister; and Mr. George Binger, Kelowna.

CLEVELAND HOSPITAL COUNCIL SETS STANDARDS FOR FURNITURE

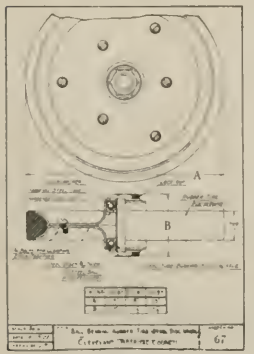
THE Cleveland Hospital Council has recently announced the first results of its standardization program as applied to hospital equipment. The various items which have received the approval of the council include a number of wheel and caster sets and several types of wheeled furniture, including trucks, serving wagons, dressing carts and stretchers.

The importance of this announcement is to be measured rather as it indicates the tendency toward the standardization of hospital equipment, than because of the special merit of the approved designs and specifications. There undoubtedly is some benefit to be gained by the standardization of requirements on the part of a limited number of similar institutions. Likewise it is important that certain minimum standards of mechanical construction be established. Whether it is possible or practical to apply arbitrary fixed standards in the mechanical construction and design of hospital equipment to the entire field is a question on which much might be said.



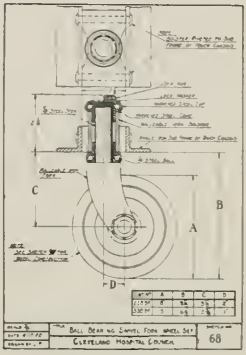
Sketch No. 66.

Many hospital executives will probably disagree with some of the detailed specifications. In fact, it is a question if the selected standards represent the latest and most approved ideas of construction in a number of instances.



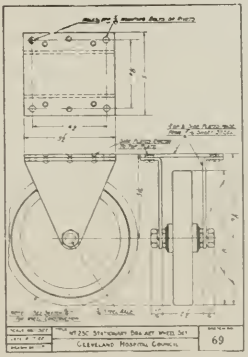
Sketch No. 67.

It is interesting to note that the council virtually has begun its standardization effort with wheels and casters, and in fact most of the furniture items which have been approved are wheeled pieces. This decidedly is a step in the right direction because there has been a tendency on the part of hospital executives and purchasing agents to ignore the wheel and caster equipment of furniture, although such part of hospital furniture is called upon to withstand the most rigorous use.



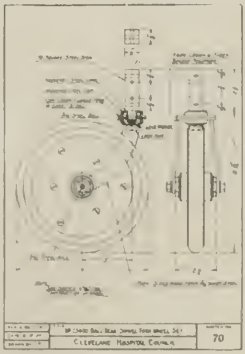
Sketch No. 68.

It would seem, however, that in preparing these standardized specifications greater attention has been paid to the wheel and caster equipment than to other essential specifications. For instance, many hospital executives will feel that the riveted construction shown on several of the trucks is more or less obsolete and scarcely to be compared with the welded construction so generally used at the present time. There is also some question of the desirability of certain designs, notably the linen hamper, as a number of other models on the market seem to offer greater advantages.



Sketch No. 69.

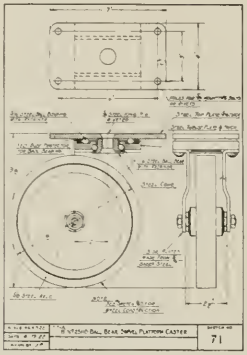
In consideration of wheels and casters emphasis has properly been laid on three essential features. Through the specification of ball-bearing hubs, easy running wheels are assured. The use of the pressed steel housing gives necessary strength without undue weight, and furthermore, enables the housing to be taken apart easily when renewing tires. The specifications, while emphasizing the necessity of quality in rubber tires, fail to give any details of specification for the rubber or rubber compound to be used.



Sketch No. 70.

Sketch 66 illustrates a

4" ball-bearing rubber tired wheel. The detailed drawing gives a clear idea of the method and type of construction with the possible exception, as mentioned above, of the quality of the rubber tires.

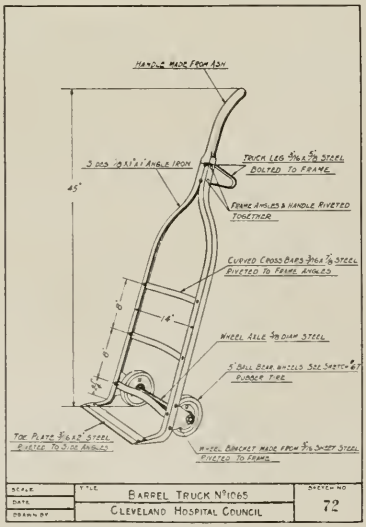


Sketch No. 71.

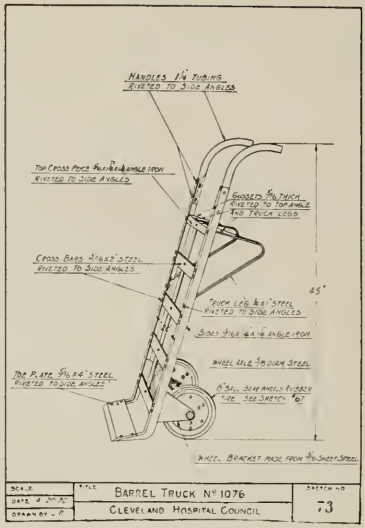
Sketch 67 presents the details of construction of 5", 8" and 10" ball bearing rubber tired wheels.

Sketch 68 illustrates the wheel shown in Sketch 67 assembled in a heavy duty ball-bearing swivel caster ready to attach to the angle frame of the truck chassis. It is to be noted that the illustration shows the angle frame members to which the castings are attached and also that the fork head projects above the frame members. This assembly is supplied for 4", 5", 8" or 10" wheels.

Sketch 69. This sketch illustrates the wheel shown on Sketch 67 assembled in a heavy duty stationary bracket ready to attach to truck chassis and is the same height as the bracket on the swivel sets shown in Sketches 68 and 71. This bracket is likewise made for 4", 5", 8" and 10" wheels.


HANDLE MADE FROM ASH
45°
FRAME ANGLES & HANDLE RIVETED TOGETHER
WHEEL AXLE 5/8" DIAM STEEL
WHEEL BRACKET MADE FROM 5/16" SHEET STEEL RIVETED TO FRAME
BARREL TRUCK N°1065
CLEVELAND HOSPITAL COUNCIL
72

Sketch No. 72.

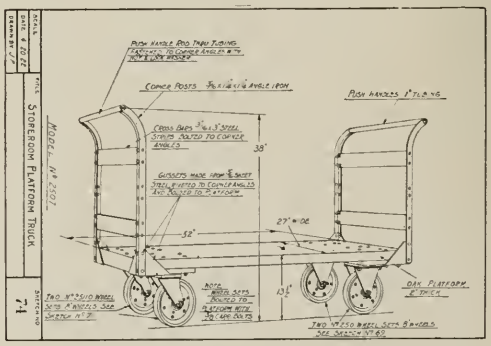

HANDLES 1¼" TUBING RIVETED TO SIDE ANGLES
CROSS BARS 3"X½" STEEL RIVETED TO SIDE ANGLES
45°
TOE PLATE 5"X4" STEEL RIVETED TO SIDE ANGLES
BARREL TRUCK N° 1076
CLEVELAND HOSPITAL COUNCIL
73

Sketch No. 73.

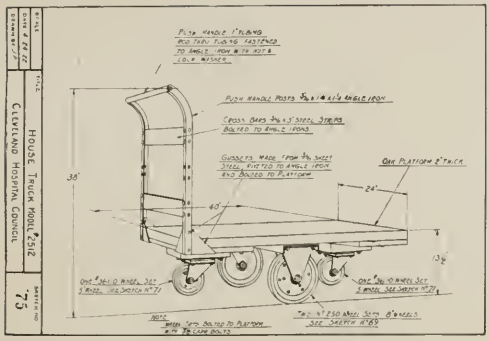
Sketch 70 illustrates the wheel shown in Sketch 67, except that the wheel is equipped with a round instead of a flat tire. In this illustration the wheel is mounted on a ball-bearing swivel fork, so designed that the stem may be securely fastened in the angle leg to permit the fork to swivel freely on the ball-bearing crown. The advantage of this type of swivel fork is that the stem does not swivel, but may be fastened securely, thus eliminating the noise and friction of a revolving form stem. This type of caster is also made in 4", 5", 8" and 10" wheels, and is made with a round stem instead of a square one as shown.

Sketch 71 illustrates a heavy duty ball-bearing swivel caster, ready to attach to the bottom of the truck. This design is especially adapted to heavy work where it is advisable to keep the platform of the truck as close to the floor as possible. The wheel is the same as illustrated in Sketch 67 and is made in 4", 5" or 8" size, matching up in height with the stationary set shown on Sketch 69.

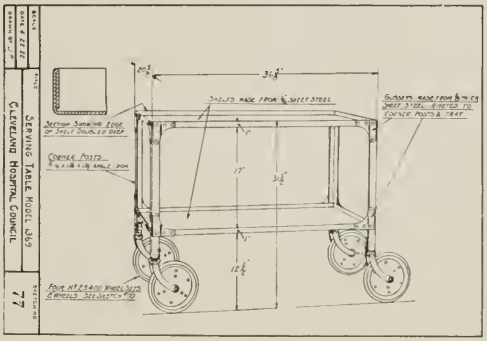
Sketch 72. This is a light weight general utility truck. It is claimed that this truck while easily handled will carry



Sketch No. 74.



Sketch No. 75.



Sketch No. 77.

an unusually heavy load. It is equipped with the ball-bearing wheels shown on Sketch 67.

Sketch 73 illustrates a heavy duty truck, likewise equipped with the wheels shown on Sketch 67.

Sketch 74 is a heavy service platform truck, equipped with two swivel casters as shown on Sketch 71, and two stationary casters as shown on Sketch 69. In both instances the wheels used are shown on Sketch 67.

Sketch 75 is the same general type as Sketch 74, except for the caster equipment and push handle. On this truck the stationary brackets are attached to the center of the platform with a swivel caster on each end. This permits turning the truck in its own length, which is a convenient feature.

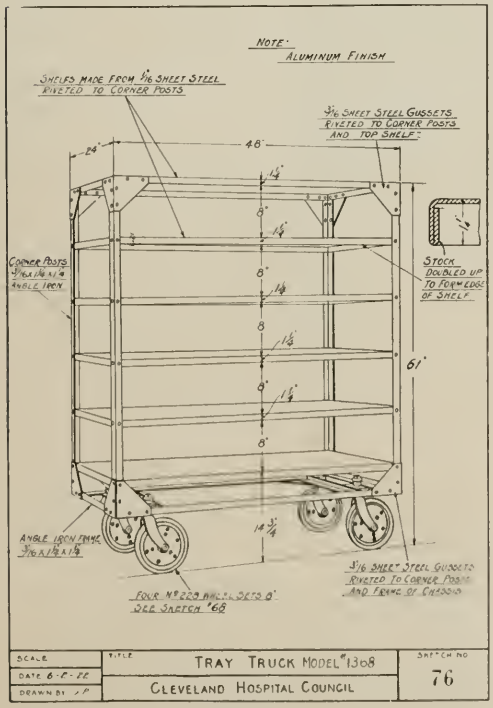
Sketch 76. This is a standard type of tray truck. The frame is made of steel angles supported by steel gussets running both ways at all corners. The shelves are made of one piece of sheet steel folded over on the sides and ends and turned up on the underside for extra strength, this feature being shown in small detail sketch. The chassis is equipped with four swivel casters as illustrated in Sketch 68, with both ball-bearing wheels and ball-bearing swivel fork heads.

Sketch 77 represents a plain, simple, yet substantial serving table. The details of construction are similar to the tray truck on Sketch 76, except that the shelves are assembled with the edges turned up forming a tray. The chassis is equipped with ball-bearing swivel casters as illustrated on Sketch 70.

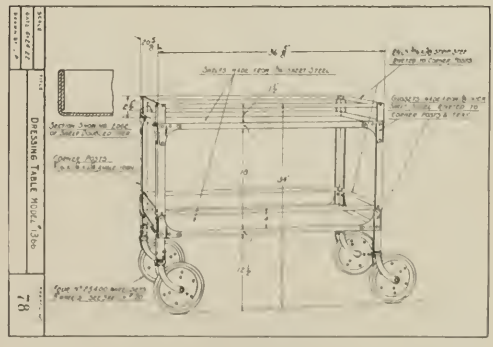
Sketch 78. This dressing table or carriage is of simple design. The trays are made of one-piece of sheet steel with a double fold of the stock on the sides and ends, and with every tray supported by steel gussets running both ways at each corner. The chassis is equipped with casters shown on Sketch 70.

Sketch 79. This dish truck is designed for heavy duty with the elimination of all unnecessary noise. The wheel equipment is illustrated on Sketch 68 and Sketch 69. The frame is of angle steel, the shelves being made of strap steel, rivetted to side angles.

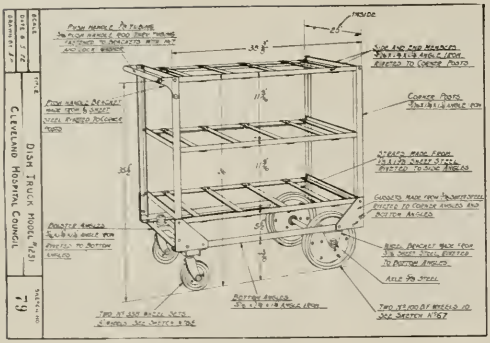
Sketch 80 shows the wheel stretcher. Sketch 80-A shows


NOTE: ALUMINUM FINISH
SHELVES MADE FROM 3/16 SHEET STEEL RIVETED TO CORNER POSTS
3/16 SHEET STEEL GUSSETS RIVETED TO CORNER POSTS AND TOP SHELF
CORNER POSTS 3"X3"X3/16 ANGLE IRON
STOCK DOUBLED UP TO FORM EDGE OF SHELF
ANGLE IRON FRAME 3"X3"X3/16
FOUR No 220 WHEEL SETS SEE SKETCH 66
3/16 SHEET STEEL GUSSETS RIVETED TO CORNER POSTS AND FRAME OF CHASSIS
SCALE
DATE 6-F-22
DRAWN BY J.P.
TRAY TRUCK MODEL #1308
CLEVELAND HOSPITAL COUNCIL
SKETCH NO 76

Sketch No. 76.

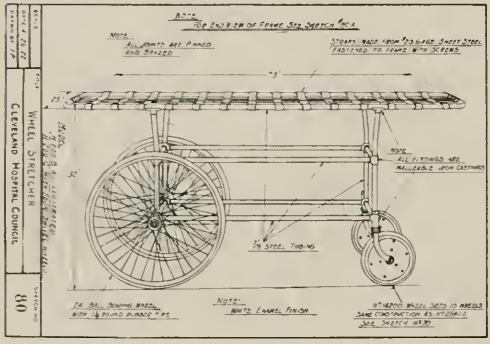


Sketch No. 78.



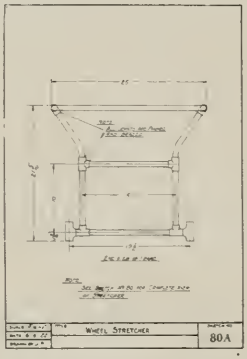
Sketch No. 79.

the detailed construction of the frame which is made of steel tubing, each joint pinned and brazed. The stretcher is made either with stationary top as shown in illustration



Sketch No. 80.

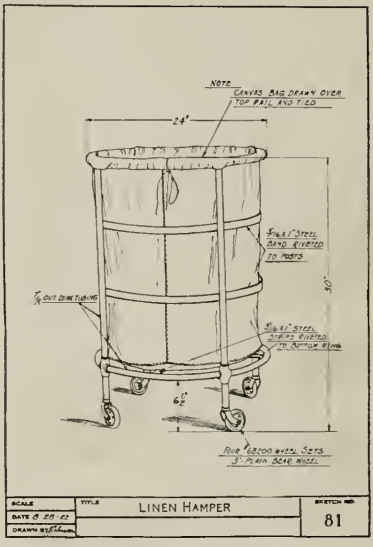
or with auxiliary removable stretcher top. The chassis is equipped with service wheel sets as shown on Sketch



Sketch No. 80A.

70 with heavy duty ball-bearing wheels on the stationary axle.

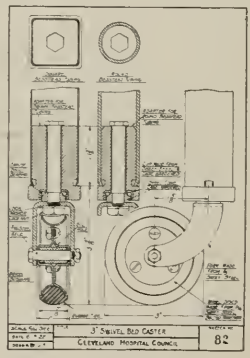
Sketch 81. This linen hamper is constructed of steel tubing, all joints brazed, forming a cage that is light in



Sketch No. 81.

weight and strong. The chassis is equipped with wheel sets as illustrated in Sketch 82.

Sketch 82. This is a ball-bearing swivel bed caster, which is designed to move a heavy load easily and quietly. The wheel is substantially made and may be easily taken



Sketch No. 82.

apart for tire replacement. The bearing is unusually large and fits the axle perfectly, which will insure a quiet, easy running wheel. The fork swivels on ball-bearings which are machined, turned and hardened.

What would life be without loyalty? Loyalty is the finest fibre in the human breast; it awards alike the humble and the great; makes the small man big and the big man bigger. Take loyalty from the heart of a saint, and you have the likeness of a devil. The greatest thing in life is man's loyalty to man, that hearty quality of true manhood, that innate stamp of fair play which prompts us to hand out the square deal instead of the double cross.

DIETITIANS TO ASSEMBLE AT NATION'S CAPITAL FOR FIFTH ANNUAL SESSION

WASHINGTON, D. C. with its stately temples of government will furnish the background for the fifth annual convention of the American Dietetic Association to be held October 16-18, although on the closing day of the conference the scene will shift to Baltimore and Johns Hopkins Hospital. Final preparations are being made for what it is hoped will be the largest single gathering of dietitians ever assembled.

The New Willard Hotel, one of the country's finest hostelries, is to be the convention headquarters, and the majority of delegates have reserved rooms under that roof. The Raleigh, the New Ebbitt and Grace Dodge Hotel are also well booked up for the convention dates.

The program, which is printed in full below, gives promise of great profit to dietitians, both in subject matter and speakers. Sidetrips to the home economics bureau of the U. S. department of agriculture and to Walter Reed Hospital in Takoma Park also will take the interest of all the delegates.

Government personages in the field of health and hospital service will be guests of honor and speakers at a banquet on the opening night of the convention, at which the president, Mrs. Mary de Garmo Bryan will preside; among them are Surgeon General Hugh S. Cumming of the U. S. Public Health Service; Major Julia C. Stimson, superintendent of the Army Nurses' Corps; Mrs. Lenah Higbee, superintendent of the Navy Nurses' Corps; and Miss Lucy Minnegerode, superintendent of Public Health Service Nurses' Corps.

MARY DE GARMO BRYAN
President, American Dietetic Association.

Social events will reach the climax on Wednesday afternoon of the convention when Mrs. John D. Rockefeller Jr., assisted by Mrs. Calvin Coolidge, wife of the vice president; Mrs. Henry C. Wallace, wife of the secretary of agriculture; and Mrs. Hugh S. Cumming, wife of the surgeon general of the U. S. P. H. S., will entertain the delegates at tea at the Grace Dodge Hotel.

After the inspection trips to the Walter Reed General Hospital and the department of agriculture on Tuesday a picnic supper is to be served.

On Thursday the entire association will be the guest of Johns Hopkins Hospital in Baltimore. A morning program will be held at the hospital auditorium with two professors at the Johns Hopkins medical school as speakers. The dietitians will have luncheon in the hospital and will spend the afternoon at the hospital and clinic.

Will Hear Report on Italian Diet

One of the events on the general program of addresses which will be awaited with interest is the report of the Committee on Italian Dietary Survey of which Mrs. Gertrude G. Mudge is the chairman. Members of the committee are: Reba Reed, Association for Improving the Condition of the Poor, New York; Mrs. W. B. S. Thomas, New York; Pearl Shackelford, student dietitian at Peter Bent Brigham Hospital, Boston; Ruth A. Johnson, assistant director of the Visiting Housekeepers' Association, Detroit; and Fairfax Proudfit, of the out-patient department, University of Tennessee Hospital, Memphis.

Officers of the American Dietetic Association for 1922 are: president, Mrs. Mary de Garmo Bryan; first vice president, Miss Helene Pope; second vice president, Miss Octavia Hall; secretary, Miss E. M. Geraghty; treasurer, Miss Ellen M. Gladwin.

The program follows:

MONDAY, OCTOBER 16

10 a. m.

Dr. Ruth Wheeler, University of Iowa Medical College, Iowa City, presiding.
Education section.
"The Dietitian—a History."
Agnes O'Dea, Johns Hopkins Hospital, Baltimore.
"The Dietitian—a Statistical Study."
Breta M. Luther, Cook County Hospital, Chicago.
"The Dietitian—A Prophecy."
Ruth Wheeler, professor of nutrition, University of Iowa Medical College, Iowa City.

2 p. m.

Helene Pope, Margaret Morrison College, Pittsburgh, presiding.
Program.
"The Dietitian and the Diabetic."
Elliot P. Joslin, M.D., Boston.
"A Nutrition Experiment in Industry."
Laura Comstock, Eastman Kodak Company, Rochester, N. Y.
"Atmosphere and Personality in the Tea Room."
Laura N. Piper, manager, Laura Matilda Tea Room, New York.
"Findings in China."
Emma Gunther, Teachers College, Columbia University, New York.
"Housewifery in China."
Ray Balderston, Teachers College, Columbia University, New York.

7 p. m.

Mary DeGarmo Bryan, Jersey City, N. J., presiding.
Dinner at New Willard Hotel. Speeches by
Hugh S. Cumming, M.D., Surgeon general, U. S. Public Health Service, Washington.

E. M. GERAGHTY
Secretary, American Dietetic Association.

Major Julia C. Stimson, superintendent, Army Nurses Corps, U. S. A.

Mrs. Lenah Higbee, superintendent, Navy Nurses Corps, U. S. N.

Miss Lucy Minnegerode, superintendent of nurses, U. S. Public Health Service.

TUESDAY, OCTOBER 17

9:30 a. m.

Rena Eckman, director of housekeeping and dietetics, University of Michigan, Ann Arbor, presiding.

Dietotherapy administrative section.

"The Role of High Protein in the Etiology of Nephritis."
L. H. Newburgh, M.D., University of Michigan Hospital, Ann Arbor.

"A Laboratory for the Preparation and Service of Research Diets."
Dorothy M. Stewart, department of dietetics, University of Michigan, Ann Arbor.

"Hospital Food Costs."
Leroy E. Perkins, M.D., assistant superintendent, Peter Bent Brigham Hospital, Boston.

"Getting Food to the Patients."
Henry C. Wright, Hospital and Institutional Bureau of Consultation, New York.

2 p. m.

Visits to Walter Reed General Hospital and Office of Home Economics, U. S. Department of Agriculture.

8 p. m.

Octavia Hall, Peter Bent Brigham Hospital, Boston, presiding.

Program.

"Nutrition and Diet in Childhood."
Mary S. Rose, Teachers College, Columbia University.

"The Relation of Hygiene to the Growing Child."
Alfred Hess, M.D., New York.

WEDNESDAY, OCTOBER 18

10 a. m.

Mrs. Gertrude G. Mudge, Committee of Italian Dietary Survey, presiding.

Social service section.

Presentative of Committee Report of Italian Dietary Survey. Gertrude G. Mudge, chairman; committee members: Reba Reed, Association for Improving the Condition of the Poor, New York; Mrs. W. B. S. Thomas, New York; Pearl Shackelford, student dietitian, Peter Bent Brigham Hospital, Boston; Ruth A. Johnson, assistant director, Visiting Housekeepers' Association, Detroit; Fairfax Proudfit, Out-Patient Department, University of Tennessee Hospital, Memphis.

"The Interrelation of the Dietitian and the Medical Social Worker."
Ida M. Cannon, director of social service, Massachusetts General Hospital, Boston.

"Factors Other than Food in the Nutrition Problem."
Lucy Gillett, director Nutrition Bureau, A.I.C.P., New York.

"Nutritional Activities in Philadelphia."
Anna Louise DePlanter, Child Federation, Philadelphia.

"Psychological Aspects of Some Problems in Dietary Administration."
John B. Watson, M.D., J. Walter Thompson Co., New York.

2 p. m.

Mrs. Mary DeGarmo Bryan, presiding.

Program.

"Hunger and Thirst."

ELLEN M. GLADWIN
Treasurer, American Dietetic Association.

A visit will be paid by delegates to the Walter Reed General Hospital, of which the above is an airplane view.

Walter Cannon, M.D., professor of physiology, Harvard Medical School, Boston.

Business meeting.

Reports of committees.

Tea (5 p. m.) Served by

Mrs. John D. Rockefeller, Jr., hostess.
Mrs. Calvin Coolidge.
Mrs. Henry C. Wallace.
Mrs. Hugh S. Cumming.

8 p. m.

Genevieve Field, Walter Reed General Hospital, Washington, D. C., presiding.

All-member program.

"The Food Service for Private Patients."
Lulu Graves, supervising dietitian, Mount Sinai Hospital, New York.

"The Food Service for Ward Patients."
Marjory Hulsizer, dietitian, Barnes Hospital, St. Louis.

"The Food Service for School Children."
Daisy Treen, director, School Lunch and New England Kitchen, Women's Educational and Industrial Union, Boston.

"The Food Service for the Hotel."
Mary Lindsley, manager, Grace Dodge Hotel, Washington, D. C.

THURSDAY, OCTOBER 19

(Johns Hopkins Hospital, Baltimore.)

10 a. m.

Lulu Graves, supervising dietitian, Mount Sinai Hospital, New York, presiding.

Program.

"The Relation of Animal Experimentation to Dietetics."

The final day's session will be held at Johns Hopkins Hospital in Baltimore.

E. V. McCollum, M.D., professor of chemical hygiene, Johns Hopkins Hospital, Baltimore.
"The Relation of the Medical Staff and Diet School in Johns Hopkins Hospital."

New Willard Hotel at Washington is convention headquarters.

William S. McCann, M.D., associate physician, Johns Hopkins Hospital.

12:30 p. m.

Luncheon.

2 p. m.

Inspection of hospital and clinic.

NEWS ITEMS

The September meeting of the Chicago Dietetic Association was held at the Hospital Library and Service Bureau on the evening of Friday, September 15. Those attending this meeting had the privilege of hearing Dr. Solomon Strouse describe the treatment of nephritis. Dr. Strouse explained the newer methods of treating diabetes.

The Chicago program for the coming year will include discussions by the best medical men in the city on the treatment of diabetes, nephritis and gastro-intestinal disorders.

The July meeting was held at the Social Workers Country Club at Riverside, Ill., where canoeing on the silvery Des Plaines and woodland festivities in the adjoining forest preserve were the order of the day. The meeting adjourned later to partake of a delicious repast, doubly enjoyable because of the cook, who, knowing nothing of dietetics, omitted all calories, proteins, carbohydrates and served only food.

Personals

Miss Breta Luther, vice president of the Chicago association and former dietitian at Cook County Hospital, has accepted a position at the Children's Hospital in Boston. She is succeeded at Cook County by Miss Marie Youmans who has been assistant dietitian at Johns Hopkins Hospital, Baltimore. Miss Sadie Hahn from Peter Bent Brigham, Boston, is her assistant.

Miss Kate Helzer is equipping the kitchen and organizing the dietary department at Polyclinic Hospital, New York. Miss Helzer gave up her position at Western Pennsylvania Hospital, Pittsburgh, to study at Columbia during the summer.

Miss Gertrude Oehmig severed her connection with the hospital at Shreveport, La., and is managing a cafeteria in Chattanooga, Tenn.

Miss Elizabeth Cooper, formerly assistant dietitian at Methodist Hospital, Brooklyn, is now dietitian at St. Bartholomew Hospital, New York.

Miss Carolyn Kling of Grace Hospital, Detroit, and Miss Maud Shackett of Herman Kieter Hospital, have joined the Hotel Statler organization.

PUBLIC HEALTH WORKERS WILL ASSEMBLE AT CLEVELAND

Cleveland, Ohio, will be host to the American Public Health Association at its fifty-first annual meeting on October 16-19. Association headquarters are at the Hotel Statler.

Addresses of welcome, according to the preliminary program, will be made by Dr. J. J. Thomas, representing Cleveland social, medical and health groups; Newton J. Baker, former secretary of war, who is president of the Cleveland Chamber of Commerce; and Ralph Perkins, chief of the department of public welfare of Cleveland. Dr. A. J. McLaughlin of Washington, D. C., is the president.

Comprehensive programs have been outlined for the various sections: public health nursing, industrial hygiene, food and drugs, vital statistics, child hygiene, sanitary engineering, public health administration, and health, education and publicity. The section on industrial hygiene will hold joint sessions with the Ohio Association of Industrial Physicians of which Dr. Sydney S. McCurdy, medical director of the Youngstown Sheet & Tube Company, is the president. Dr. Wade Wright of the Harvard School of Public Health is chairman of the industrial section.

R. E. Doolittle of the U. S. Department of Agriculture, Bureau of Chemistry, is chairman of the food and drugs section at which some important reports are to be presented. The chairman of the sanitary engineering section is W. H. Dittoe of the state department of health, Columbus, Ohio.

John Dill Robertson of Chicago is chairman of the public health administration section.

MISSISSIPPI VALLEY CONFERENCE ON TUBERCULOSIS MEETS

The Mississippi Valley Conference on Tuberculosis holds its annual session October 9-11 in Milwaukee, with President Robinson Bosworth, M.D. of St. Paul in the chair. Concurrently on the final day of the meeting will be held the annual conference of the Mississippi Valley Sanatorium Association. The latter organization will hold its morning session at Muirdale Sanatorium and conference in the afternoon at Blue Mound Sanatorium, both at Wauwatosa. Hotel Phister in Milwaukee is the headquarters of the main convention.

Among the speakers are Owen R. Lovejoy, general secretary of the National Child Labor Committee; Dr. Linsley Williams, managing director of the national association; Philip P. Jacobs, publicity director of the national organization; and C. M. DeForest, Modern Health Crusade executive of New York.

At the nurses' meeting scheduled for the Wednesday afternoon (October 11) session, Mrs. Mary P. Morgan, director of the bureau of child welfare and public health nursing of the Wisconsin State board of health, will preside. A debate will make up the major part of the program, the question being: "Resolved: that tuberculosis nursing is more effective when it is specialized than when it is part of a generalized program."

Dr. A. T. Laird, superintendent of Nopeming Sanatorium in Nopeming, Minn., is president of the sanatorium association and will preside at its sessions.

CLINICAL CONGRESS WILL CONSIDER HOSPITALS

FOLLOWING the custom established last year at Philadelphia, the first day's program of the Clinical Congress of the American College of Surgeons will be devoted entirely to hospital matters. The Congress will be held in Jordan Hall, Boston, October 23-27.

Dr. Frederick W. Slobe of the College has announced the following tentative program for the hospital conference:

9:30 to 12:30 a. m.

President, John B. Deaver, M.D., F.A.C.S., presiding.

Report of the Standardization Activities of the College in 1922.
Franklin H. Martin, M.D., F.A.C.S., director-general, American College of Surgeons, Chicago.

The Doctor and the Hospital.
Frederic A. Washburn, M.D., superintendent, Massachusetts General Hospital, Boston.

The Minimum Standard and its Application to Hospitals.
Frederick W. Slobe, M.D., hospital standardization department, American College of Surgeons, Chicago.

What Real and Lasting Benefit Has Come to the Patient from Hospital Standardization?
Rev. Charles B. Moulinier, S. J., president, Catholic Hospital Association, Milwaukee.

The American Hospital.
A. R. Warner, M.D., executive secretary, American Hospital Association, Chicago.

Hospital Standardization from a Public Health Standpoint.
D. A. Craig, provincial commissioner, Nova Scotia Division, Canadian Red Cross, Halifax, Nova Scotia.

Hospital Standardization from the Viewpoint of the Medical Staff.
R. A. Hughes, M.D., Moncton, New Brunswick.

Sidelights on Hospital Standardization.
Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

The Analysis of End Results.
Eugene H. Pool, M.D., F.A.C.S., New York.
E. A. Codman, M.D., F.A.C.S., Boston.

General Summary of Hospital Standardization.
Malcolm T. MacEachern, M.D., C.M., director-general, Victorian Order of Nurses for Canada, Ottawa.

2 to 4:30 p. m.

Round table discussion conducted by M. T. MacEachern, M.D., C.M.

The round table discussion will be confined largely to the requirements of the minimum standard. Hospital superintendents, staff members and members of boards of trustees, are urged to send in questions which they desire to be answered, in order that the discussion may shed light on the various difficulties encountered. After representative speakers have opened the discussion of these questions, the subsequent discussion will be open to all. A tentative list of the topics to be considered follows:

Staff organization.
1. The selection of the exact type of staff organization best suited to local needs.
2. The division of responsibility into representative committees.
3. The initial organization of the staff conference.
4. The agenda and description of the staff conference.
5. Methods of stimulating interest in staff conferences.
6. Monthly analysis of hospital work.

Case records.
1. The component parts of a case record.
2. Methods of securing the records.
3. Methods of stimulating increased interest in records.
4. The hospital historian or record clerk.
5. Filing systems, card indices, disease nomenclatures and follow-up systems.

Laboratories and x-ray facilities.
1. Methods of stimulating increased use of laboratories by the medical staff.
2. Relationship of laboratory charges to laboratory service, and the various systems of laboratory charges commonly employed.
3. The extent to which routine laboratory examinations should be employed.
4. Laboratory facilities in the small hospital.
5. Laboratory reports and filing systems.
6. What should constitute the complete service in an x-ray department?
7. The interpretation of x-ray plates by roentgenologists versus interpretation by individual physicians.
8. To what extent can x-ray facilities outside of the hospital be used satisfactorily.

Miscellaneous.
1. What points in particular should the hospital surveyor investigate in making his annual visit.
2. Making the public understand the value of hospital standardization.
3. Methods of increasing the efficiency of the hospital survey of the College.

Including the speakers of the morning program, the following names are a partial list of those who have been invited to lead in the discussion:

John M. Baldy, M.D., F.A.C.S., Philadelphia.

John G. Bowman, chancellor, Pittsburgh University, Pittsburgh.

John F. Bresnahan, M.D., Superintendent, Bridgeport Hospital, Bridgeport, Conn.

Frank E. Chapman, superintendent, Mount Sinai Hospital, Cleveland.

Pliny O. Clark, president, Protestant Hospital Association.

Rev. Newton E. Davis, Chicago.

E. T. Dillon, M.D., F.A.C.S., Los Angeles.

Matthew O. Foley, managing editor, *Hospital Management*, Chicago.

S. S. Goldwater, M.D., superintendent, Mount Sinai Hospital, New York.

Charles A. Gordon, M.D., F.A.C.S., Brooklyn.

R. M. Harbin, M.D., F.A.C.S., Rome, Ga.

A. K. Haywood, M.D., superintendent Montreal General Hospital, Montreal.

Joseph B. Howland, M.D., superintendent, Peter Bent Brigham Hospital, Boston.

Roy C. Kingswood, M.D., London, Ontario.

Henry M. Pollock, M.D., superintendent, Massachusetts Homeopathic Hospital, Boston.

W. C. Rappleye, Rockefeller Foundation.

Brigadier General C. E. Sawyer, M.C., U.S.A.

George W. Swift, M.D., F.A.C.S., Seattle.

Joseph J. Weber, editor, THE MODERN HOSPITAL, Chicago.

H. E. Webster, superintendent, Royal Victoria Hospital, Montreal.

Horace G. Wetherill, M.D., F.A.C.S., Denver.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

WHY MANY NURSES HAVE SHUNNED THE FIELD OF MENTAL HYGIENE

BY HARRIET BAILEY, R.N., EDUCATIONAL DIRECTOR OF NURSES, BELLEVUE AND ALLIED HOSPITALS, NEW YORK.

WITH great interest I have read the article of Dr. Vernon Briggs, "Mental Hygiene in its Relation to Present-day Nursing," in the September issue of THE MODERN HOSPITAL; and while I am impressed with the fairness and justice of much that he says, it seems to me there are some things which should be offered in explanation of the present situation in mental nursing, for the problem he presents cannot be solved by the nursing group alone.

Inasmuch as nursing has ever been the "hand maiden of medicine" it is not to be expected that the nursing of mental patients could reach a higher level than the medical care and treatment which for so long a period made little advancement in the scientific study and treatment of these diseases. For too long hospitals for mental patients, "asylums" so-called, were little more than places of detention to which all those unfortunate individuals in the community who were unable to adapt themselves to the ever changing complexities of their social environment were, after being adjudged insane, committed under the provisions of the law for a period limited only by their ability to regain their mental health; and, I may add, with little more help in doing so than the nursing staff could offer.

Mental Hospital Conditions Not Attractive

The nursing care at this time consisted mainly of preventing these patients from harming others or injuring themselves, of seeing that they received a reasonable amount of food, were kept clean and performed as much work for the institution as they were able. To prepare the nurse for this care a few classes were given in which the care of the keys, simple precautions against accidents and escapes, and various aspects of hospital housekeeping were emphasized.

Until comparatively recently the state hospitals and a limited number of private hospitals offered the only opportunities for young women to obtain training and experience in this branch of nursing. Training schools for nurses existed in some of these, but the educational standards were for the most part below those of the majority of general hospital training schools.

It is not primarily because of fear or prejudice that young women have not chosen to undertake the care of patients in mental hospitals, but because the conditions within these hospitals have not been such as to attract them. It is not so many years since these nurses were expected to be on duty for twelve to fourteen hours daily, and at the end of busy and oftentimes strenuous days to retire to their rooms which were situated on the wards, very often wards in which the patients were noisy and disturbed. They had always the expectation of being called at least one or more times during the night to assist in the management of difficult and excited patients. The nurses' comfort was the last consideration, nor were any opportunities provided for recreation. They were supposed to have some mysterious springs of refreshment and vitality which could recreate them under these trying conditions, renew their patience and strength, and make them fit to take up the arduous duties of the following day.

Nurse's Position Has Been Subordinate

Then, too, the nurses in many mental hospitals have been, and now are, too often looked upon as subordinates, not as co-workers. They have been made to feel that they must obtain all their initiative from the physicians; that they are principally makers of beds and dispensers of food and drugs. The patient's illness is rarely discussed with them. They never read a history. They know little or nothing of the onset of the illness, the factor or factors which precipitated it or those which are active in prolonging it. Very little instruction is given to help them to recognize and interpret the mental symptoms, or to apply the most apparent and needful nursing measures.

What incentive, I ask, can there be for young women to enter upon a work, or keep at it, in which they may be scratched, kicked, spat upon, have their hair pulled and clothing torn, unless they are able to interpret these acts as the expressions of serious mental illness and not of temper or bad disposition?

How can we expect a nurse to spend long hours with patients who are acutely depressed, or acutely excited, or indifferent or apathetic, and find at every turn that her efforts at amelioration are blocked because she has no understanding of the mechanism of disordered behavior, emotions or intellect? No nurse will shirk or shrink from hard or disagreeable duties if by the performance of these tasks she is able to relieve the mental distress and assist the patient back to health. For, after all factors are considered, this provides the largest compensation in nursing service, for it brings contentment and satisfaction and

arouses enthusiasm without which much of the work would descend to the level of drudgery.

One nurse of much intelligence and many years of administrative experience in mental hospitals has recently said:

"If spontaneously one of the physicians should ask me for reactions or discuss with me a patient's condition, I would mentally swoon, the shock would be so great. The result to me? I am in a state of stasis. Progress seems impossible when nursing measures consist only of feeding, bathing and putting the patient to bed. What stimulus have I to pass on to my nurses? And is it to be wondered at that the nurses in the wards readily say 'There's nothing in it'?

"If a fracture occurs on the ward, or a case of typhoid fever develops, a clinic is held while the physician explains the symptoms, signs and treatment, and discusses the nursing measures which may be applied. Why should not the symptoms, signs and treatment of mental diseases be as freely discussed with the nurses?"

And why is it we find that so many nurses who have received valuable training in the care of mental patients are not following this branch of nursing? Why do we find them choosing work in tuberculosis wards, in chronic medical wards and other branches of general nursing? Their reply is that they are discouraged by the outlook, because they have to scramble and grope for knowledge, even to beg for it in order that they may minister at all efficiently to the needs of their patients. They all admit that though the work is hard, it is not too hard providing they could find satisfaction in it and opportunity for growth and development.

Proper Instruction Arouses Enthusiasm

In the training school of a large general hospital which has an active psychiatric department the nurses during their period of training are assigned to two months' service in this department. They are so enthusiastic about the work and find the mind is so much more interesting to study and nurse than the body that they invariably ask to have their period of service prolonged, and many elect to give a much longer period to post graduate study. In this hospital the nurses are given a very carefully prepared course of instruction in mental diseases, the principle and practice of mental nursing, occupational therapy, hydrotherapy, electrotherapy and mechanotherapy.

That there is a growing need and a more insistent demand for nurses who are trained in the care of mental diseases can no longer be overlooked or unheeded. Many schools of nursing are already providing courses of instruction in this subject, and while a short course of two or three months is not enough to prepare a nurse to specialize in any branch of psychiatric work, it will give her a knowledge which will help her better to understand and nurse all her patients, and will provide a basis upon which to build for future specialization.

Mental Hospital Is Best for Training

How then can this need for nurses trained in the care of mental diseases be met? Mental hospitals will always offer the best opportunities for this training, because all types of mental disorders are represented and all grades of symptoms may be noted. The patients in these hospitals are usually carefully classified, and these larger groups give a more outstanding picture of the various types. These hospitals should be able to offer excellent courses to nurses who wish to affiliate or to pursue post graduate study in psychiatry, occupational therapy, hydrotherapy, mechanotherapy, and the principles and practice of mental nursing, with adequate supervision on the wards by special instructors or teaching supervisors who would correlate the theory with the practical nursing. Clinics, too, should be held in which the physicians would demonstrate and explain the symptoms, signs and treatment of the various forms or types of mental disorder and disease, and outline and discuss the special nursing procedures which are applicable to each.

I believe that physicians who know the need must talk and preach and persuade the value of psychiatric nursing to training schools, to society and to the medical profession and must create the same enthusiasm for this branch of the healing art that an internist or surgeon inspires in his nurses. These nurses would in turn arouse the interest of other nurses both in and out of training. Superintendents of training schools and training schools committees would soon feel the enthusiasm and look to the subject with thought and not with reluctant obligation.

When schools of nursing are operated upon an educational basis, without hospital economics entering so largely into consideration, it will not be a question whether nurses can be "spared" to take duty in the psychopathic department or affiliated mental hospital, but it will be a question as to the maximum time that in fairness can be devoted to this subject.

1922 DEATH RATE IS HIGHER AND BIRTH RATE LOWER

The Department of Commerce announces that provisional mortality figures compiled by the bureau of the census for the first quarter of 1922 indicate higher death rates than for the corresponding quarter of 1921. For the states compared the death rate for the first quarter was 13.7 in 1922 against 12.6 for the first quarter of 1921. The highest mortality rate for the quarter is shown for the District of Columbia (17.6) and the lowest for Wyoming (9.6). These early figures forecast for the year 1922 a higher rate for the death registration area than the record low rate (11.7) for the year 1921.

Provisional birth figures compiled by the Bureau of the Census for the first quarter of 1922 indicate lower birth rates than for the corresponding quarter of 1921. For the states compared the total birth rate for the first quarter was 23.3 in 1922 against 25.3 in 1921. The highest birth rate for the quarter (29.2) is shown for North Carolina and the lowest (16.5) for the state of Washington. Higher rates will be necessary for the remaining months of the year if the 1922 rate is to equal the 1921 rate for the birth registration area—24.3.

NOT MODERN HOSPITAL PHOTOGRAPHER

Activities of an imposter, representing himself as an official photographer for THE MODERN HOSPITAL, still continue, and warning is again sounded to hospital executives not to grant any person entree to their institutions on the grounds that he is a representative of this magazine, unless he can furnish proper credentials.

Entrance into the Michael Reese Hospital of Chicago was sought recently by a J. H. Armstrong who presented the card of the American Reserve and Supply Co. of New York and declared that he was authorized to take some photographs for THE MODERN HOSPITAL. When the superintendent questioned the authenticity of his claim, he made a strenuous effort to secure the return of his card.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

A STUDY OF DIETETICS COURSES FOR PUPIL NURSES GIVEN IN CLASS "A" HOSPITALS*

BY HELEN CLARKE, M.S., COLUMBUS, OHIO.

THIS is a study of standards of dietetic instruction for pupil nurses. It is based on replies to questionnaires which were sent to all the hospitals in the United States and Canada, 422 in number, which in 1921 had been given the fullest approval of the American College of Surgeons. The list of approved hospitals was given in THE MODERN HOSPITAL, November, 1921, Vol. XVII, No. 5, pages 405-408. In order to present the questions exactly as they were used in making this survey, a copy of the questionnaire is quoted.

Replies were received by January 1, 1922, from 201, or 48 per cent, of the institutions. The questionnaires had been out a little more than a month. Of the replies 14 were from hospitals which have no training school and six were too indefinite to use. The 181 remaining questionnaires from 43 per cent of the hospitals questioned are the basis of the tables and discussions of this report.

The Questionnaire Sent Out

I. The instructor and methods of instruction in classroom work in dietetics.
   1. Is the instructor a graduate nurse?.....
   2. Is the instructor a graduate
      a. Of a two-year home economics course?.....
      b. Of a four-year home economics course?.....
      c. Of some other kind of course.....(Specify).....
   3. Does the instructor have other work in connection with the hospital, such as
      a. Purchasing food? .....
      b. Planning diets? .....
      c. Management of kitchen employes?.....
   4. Is the method used in teaching dietetics the lecture?..... The recitation?.....Recitation and lecture?.....
   5. In what year or years of the nurse's course is the dietetic classroom work taken?.....

II. Textbook.
   1. What textbook do you use in dietetics?.....
   2. Would the instructor prefer some other book?.....
      a. Because the one now used is too long?.....
      b. Too technical? .....
   3. Do you supplement the material in the textbook by using in lectures articles from current journals?.....

III. Laboratory work in dietetics.
   1. Is there laboratory work in connection with classroom work? .....
   2. In what year is it given?.....
   3. Do you use a laboratory provided for the purpose?.....
   4. Do you use a kitchen for the dietetics laboratory?.....
   5. What is done with the food prepared?.....
   6. What laboratory manual do you use as a guide for the work? .....
   7. Does the laboratory work include preparation of special diets? .....
   8. Do you give work in the preparation of formulas for infant feeding? .....
   9. Are menus for general standard diets prepared by the class? .....
   10. Do the nurses have opportunity to practice planning menus for their own table?.....
   11. Is any instruction given in purchasing food supplies?.....

IV. Practical work in the diet kitchen.
   1. In what year of the nurse's course does practical work in the diet kitchen come?.....
   2. How many weeks does it last?.....
   3. Is there a definite outline of the work to be done by the nurse while she is in the diet kitchen?.....
   4. Does the classroom work precede the diet kitchen work?....
   5. Who is in charge of the pupil nurse while in the diet kitchen? .....

V. General.
   1. Do you consider that the average nurse dislikes dietetics? .....
   2. If the nurse dislikes dietetics do you feel that it is because of
      a. Lack of preliminary work before entering the hospital? .....
      b. Lack of preliminary work after entering the hospital? .....

The hospitals returning usable questionnaires are classified by bed capacity in Table I.

TABLE I.

Number of Hospitals Studied, Listed by Bed Capacity.

Bed Capacity	Number Reporting
100-149	60
150-199	42
200-249	13
250-299	15
300-349	7
350-399	8
400-449	7
450-499	3
500-549	4
550-599	1
600-649	2
650-699	0
700-749	0
750-799	1
800-849	2
850-899	1
1000-2000	5
Total for United States	171
Total for Canada	10
Total usable questionnaires	181

The bed capacity of the hospitals was obtained from *The Journal of the American Medical Association*, Hospital Number, Volume 76, No. 16, April 16, 1921, pages 1087-1103, "Bed Capacity of General Hospitals and Daily Average in Constant Use During Preceding Year." Several hospitals not given in this list were found in the *American Medical Directory for 1921.*

Canadian hospitals are studied as one seperate group (1) to see if their method of dietetic instruction shows some striking contrast to the practice in the hospitals of the United States, (2) because the number is small to classify according to size, (3) because of the difficulty in obtaining accurate information as to bed capacity.

In the following report the questions are taken up

*A thesis presented by Miss Clarke to Ohio State University for the degree of Master of Science, 1922.

in the order in which they appear in the questionnaire. In the discussion reasons are sometimes given why a particular question was asked; second, the facts reported are stated; third, the facts are interpreted:

Question I. 1. Is the instructor a graduate nurse?

2. Is the instructor a graduate

a. Of a two year home economics course?

b. Of a four year home economics course?

c. Of some other kind of course? (Specify).

TABLE II.

General Training of Dietetics Instructors.

Graduate nurse	27
Two-year course, home economics	69
Three-year course, home economics	9
Four-year course, home economics	66
Graduate course, home economics	3
Course for student dietitian	21
College course other than home economics	4
Normal course	3
One-year academic course	8
Two-year academic course	2
Other courses not specified	28
	240

The training courses reported in Table II, total 240, which is 59 in excess of the number of hospitals, because some of the hospitals have more than one instructor and each instructor is included in these totals. Moreover, some instructors have graduated from more than one course. These instructors are counted in the tabulations for each separate course, because the reports are in such form that one cannot distinquish between the reports for two instructors and those for one instructor who has had two courses. Since some persons are reported twice in Table II it follows that the amount of training received by the instructors is greater than appears on the face of the report. Unpublished tabulations show no relation between the size of the hospital and the training of the dietitian.

It is found that of the twenty-seven nurses who are dietetics instructors, nineteen have had other courses besides those included in their nursing training. One of the instructors who has done graduate work has received a Ph.D. in nutrition from Yale. Further note is made in Table III of the hospitals where, as student dietitians, instructors received training.

TABLE III.

Hospitals Where Student Dietitians Were Trained.

Hospital—	Number of students trained
Massachusetts General Hospital, Boston	5
Peter Bent Brigham Hospital, Boston	1
Bellevue Hospital, New York City	1
Jefferson Hospital, Philadelphia	1
Johns Hopkins Hospital, Baltimore	1
St. Louis City Hospital	1
Lakeside Hospital, Cleveland	1
University of Minnesota Hospital, Minneapolis	1
San Francisco City Hospital	1
Indefinite as to hospital	8
	21

This extensive supervisory work has both advantages and disadvantages. The instructor who has a diversity of diets to plan and supervise has more valuable and interesting information pertaining to dietetics than one who does not plan diets or come into intimate contact with cases largely treated by dietetherapeutic means. On the other hand, the dietitian who is purchasing foods, planning diets and managing kitchen employes must have a primary interest in this and the teaching is almost necessarily given a place of secondary importance.

4. Is the method used in teaching dietetics the lecture? The recitation? Recitation and lecture?

These questions were to determine the extent to which the different methods prevail. Answers show that in nine, or 5 per cent of the schools the lecture method is used; in four, or 2 per cent, of the schools the recitation is used; while 168, or 93 per cent, use the combined lecture and recitation. Many schools have in addition class demonstrations in connection with these lectures and recitations.

5. In what year or years of the nurse's course is the dietetic classroom work taken?

This question was asked to find out whether there is any prevailing standard. The answers, together with other facts, appear in Table V.

Textbooks in Use

Question II. 1. What textbooks do you use in dietetics?

TABLE IV.

Textbook Used.

Name of Book—	Number of schools using book
Pattee—Practical Dietetics	82
Proudfit—Dietetics for Nurses	80
Friedenwald and Ruhräh—Dietetics for Nurses	9
Strouse and Perry—Food for the Sick	4
Farmer—Invalid Cookery	1
Rose—Feeding the Family	1
Pope—Practical Dietary Computer	1
Carter, Howe and Mason—Nutrition and Clinical Dietetics	1
Pope and Carpenter—Essentials of Dietetics	1
No book used	8
Seven schools are using more than one textbook in dietetics.	

2. Would the instructor prefer some other book?

In some institutions the textbook for dietetics instruction is chosen by the superintendent of nurses or some one other than the dietitian who is connected with the training school. The book used may not suit the needs of the class as well as some other which the instructor may know and prefer. Replies show that 29, or 16 per cent, of the instructors prefer another book; 98, or 54 per cent, do not prefer some other; 54, or 30 per cent, do not report. Of those who desire to use another book, seven give as their reason that the book used is too long and six that it is too technical. Three say that the book used is too brief, one that the book used is incomplete, another that the book used is inaccurate and eleven give no reason for preferring some other book.

The American Dietetic Association is making an attempt to have better courses of training in dietetics in the hospitals as well as in the colleges. In a preliminary report of a committee working out courses for student nurses this comment is given about textbooks. "A good textbook and suitable reference books relieve students from much note-taking, but at present there appear to be few suitable books of this kind for student nurses. Some are, for the most part, a collection of recipes, while others pay too much attention to specific methods and specific information, with inadequate attention to general principles. The material presented is not always well adapted to the average general educational preparation of the class and to their vocational needs." This is quoted from THE MODERN HOSPITAL, Vol. XVIII, No. 3, March, 1922. p. 271, "The Teaching of Dietetics to Student Nurses."

3. Do you supplement the material in the textbook by using in lectures articles from current journals?

Hardly an issue of a journal of medicine or of the allied sciences fails to contain information relating to food and nutrition. The instructor may take advantage of these articles in giving new, accurate and interesting material to her classes. This is done in 140, or 77 per cent, of the hospitals. In 17, or 9 per cent, of the hospitals

the instructors say they do not supplement their lectures by current articles; 24, or 14 per cent, give no answer.

Laboratory Work in Dietetics

Question III. Laboratory work in dietetics.

1. Is there laboratory work in connection with classroom work?

2. In what year is it given?

The former question was asked to determine whether the theory is being strengthened by practice. There are 158, or 87 per cent, of the schools giving laboratory work; 16, or 9 per cent, do not give this work; 7, or 4 per cent, give no report.

TABLE V.

Year in Which Classroom and Laboratory Work is Given.

Year—	Classroom	Laboratory
1	41	72
2	20	29
3	14	11
1, 2	47	22
1, 3	18	7
1, 2, 3	17	7
2, 3	9	10
No report of year	15	0
Total	181	158

This table shows that there are twenty-three more schools giving classroom work than are giving laboratory work. Moreover, where both are given they are frequently not concurrent. In 49 cases classroom work is not accompanied by laboratory work in that year. In 41 cases there is laboratory work without classroom work in the same year.

3. Do you use a laboratory provided for the purpose?

4. Do you use a kitchen for the dietetics laboratory?

These questions were to determine whether a special arrangement is made so that the nurses have a suitable place for laboratory dietetics work. It is difficult to find a time when a hospital kitchen is free long enough to use as a class laboratory. It is also hard to find a kitchen which can be conveniently arranged for general work as well as be fitted with equipment for a class. It is, therefore, significant to see the number that use kitchens. It is found that 81, or 51 per cent, of the classes use a laboratory; 53, or 34 per cent, do not use a laboratory; 24, or 15 per cent, give no report. There are 110, or 70 per cent, of the classes which use a kitchen; 33, or 21 per cent, do not use a kitchen; 15, or 9 per cent, do not report. It is found that of these hospitals having laboratory work, 33, or 21 per cent, are using both a kitchen and a laboratory for the work.

5. What is done with the food prepared?

In 87, or 55 per cent of the classes the nurses eat the food they prepare; in 53, or 34 per cent of the schools the food is served to the patients; in 18, or 11 per cent of the schools the food is used by both the nurses and patients.

6. What laboratory manual do you use as a guide for the work?

TABLE VI.

Manual Used for Classes.

Manual—	Number of classes using manual
Rose—Laboratory Manual of Dietetics	27
Pattee—Laboratory Manual	16
Proudfit—Laboratory Manual	12
Manual prepared for use of hospital	10
Manual prepared by dietitian	8
Outline in the Standard Curriculum for Nurses Training Schools	4
Locke—Food Values	4
Stout Institute Manual	1
Bailey—Domestic Science, Principles and Application	1
Maxwell—Pope—Dietetics for Nurses	1
Farmer—Invalid Cookery	1
No manual used	29
No report given	44
Total number of schools giving laboratory work	158

7. Does the laboratory work include preparation of special diets?

The criticism is often made that nurses do not know what foods are permissible for nephritic or diabetic patients or what is meant by special diets for specific diseases. In 122, or 77 per cent of the laboratory classes work is given in preparation of special diets; 25, or 16 per cent of the classes do not give this work; 11, or 7 per cent of the classes do not report.

8. Do you give work in the preparation of formulas for infant feeding?

There seems to be a general tendency to give this work in some other department than that of dietetics. If the answer on the questionnaire indicates that the work is given in any department of the hospital the answer is included as an affirmative. There are 144, or 80 per cent of the hospitals which give this work; 25, or 14 per cent do not give this work; 12, or 6 per cent do not report.

9. Are menus for standard diets prepared by the class?

Usually each hospital has its list of permissible foods which may be included in so-called liquid, soft, light or general diets. It is necessary that a nurse know these foods and how to group them for meals. In preparing foods, planning menus and serving trays during her work in the diet kitchen it seems absolutely necessary that she be familiar with these diets. In 108, or 68 per cent of the laboratory classes menus for standard diets are prepared; 50, or 32 per cent do not give this work.

10. Do the nurses have opportunity to practice planning menus for their own table?

There are four distinct advantages in such practice: first, in planning such menus the nurses learn the dietary requirements for a normal, active group; second, they have to use nearly all the knowledge they may have gained in theoretical and practical dietetics; third, they learn that they have to consider such factors as cost of food, practicability for preparation and service in their institution. This work makes nurses less critical about their own food. Finally, whenever applicable, suggestions made by nurses in planning for their own table can be used by the dietitian in her menu planning. Reports show that 49, or 31 per cent of the laboratory classes practice planning menus for their own table; 109, or 69 per cent do not.

11. Is any instruction given in purchasing food supplies?

Reports show that 68, or 43 per cent of the laboratory classes have instruction in purchasing food while 90, or 57 per cent do not have this instruction.

Practical Work in Diet Kitchen

Question IV. 1. In what year of the nurse's course does practical work in the diet kitchen come?

2. How many weeks does it last?

Reports show that 168, or 93 per cent of the schools give this work; while 13, or 7 per cent do not have it. The years in which it is given and the length of the course are shown in Tables VII and VIII.

TABLE VII.

Year Course in Which Diet Kitchen Work is Given.

Year—	Number of hospitals
1	37
2	42
3	36
1, 2	15
1, 3	12
1, 2, 3	8
2, 3	18
Total courses	168

TABLE VIII.

Length of Course in Diet Kitchen Work.

Number of weeks	Number of hospitals
2	1
3	10
4	33
5	6
6	33
8	61
9	4
10	4
12	12
14	1
15	1
16	2
Total classes	168

The function of the training in the diet kitchen is expressed in the following quotations. "It is coming to be generally recognized that the diet kitchen is a laboratory where the student nurse may apply her technical knowledge and where she may develop a fair degree of skill in preparing food for the sick. The student is there to be taught and must not be thought of simply as a means of getting the work done. . . . Students should have some of their diet kitchen experience during their preparatory course or soon after. . . . This period should be for at least three or four weeks, the time of each student being carefully organized." The Modern Hospital, Vol. XVIII, No. 3, March, 1922, p. 271.

3. Is there a definite outline of the work to be done by the nurse while she is in the diet kitchen?

Some instructors say that the work is dependent upon the patients and their diets, others say there is a very definite outline. An outline is used by 158, or 94 per cent of the hospitals giving work in the diet kitchen; 10, or 6 per cent do not have an outline.

4. Does the classroom work precede the diet kitchen work?

The classroom work precedes or is concurrent with the diet kitchen work in 161, or 95 per cent of the hospitals, in 7, or 5 per cent, it follows the diet kitchen work.

5. Who is in charge of the pupil nurse while in the diet kitchen?

The dietitian is in charge in 156, or 93 per cent of the diet kitchens, a graduate nurse is in charge in 10, or 6 per cent. No answer is given by 2, or 1 per cent of these hospitals having diet kitchen work.

Attitude of Nurses Toward Subject

Question V. 1. Do you consider that the average nurse dislikes dietetics?

2. If the nurse dislikes dietetics do you feel that it is because of

a. Lack of preliminary work before entering the hospital?

b. Lack of preliminary work after entering the hospital?

Reports indicate that 57, or 31 per cent, of the instructors consider that the average nurse dislikes dietetics; 111, or 61 per cent, do not believe this and 13, or 8 per cent give no answer. There are 66, or 36 per cent who believe the dislike is caused by lack of preliminary work before entering the hospital. These instructors feel that many nurses lack a knowledge of chemistry. Preliminary work before entering the hospital is not believed to be the cause by five, or 3 per cent; 110, or 61 per cent give no answer. There are 19, or 10 per cent who believe a dislike is caused by preliminary work after entering the hospital; 16, or 9 per cent do not believe this the reason; and 146, or 81 per cent give no reply.

The questions concerning the true or apparent dislike of dietetics by the average nurse evoked more comments by the instructors than did any of the other questions. In classifying criticisms six main reasons are distinguished, as follows: (1) Lack of application on part of the nurse. This may be partially explained by the fact that the pupil nurses are required to do much uninteresting routine work in the diet kitchen. (2) Lack of interest in the subject. Because of their unfamiliarity with dietetics, nurses fail to realize the importance of the subject and the relation which it bears to nursing. (3) Prejudice is a factor in the dislike of dietetics for many times nurses dislike cooking and they fail to see the broader meaning of dietetics. Many instructors trace the dislike of the subject to the fact that the nurse dislikes any work connected with a kitchen. (4) Lack of time for study of the subject. In some schools it is believed that the dislike of dietetics is caused by crowding a heavy subject into a short space of time. (5) The attitude of the hospital toward the subject. A few instructors still cling to the belief that the subject is not sufficiently supported by the faculty of the training school but realize that this feeling is rapidly disappearing. (6) Factors relating to the instructor and her methods of teaching. The presentation of the subject must be interesting, the work must be correlated with the needs of actual patients and it must not be too technical. Some instructors feel that the previous training of the nurses has little influence if a clear, forceful method of teaching dietetics is followed.

Conclusions

The answers and tables give the data obtained from the answers to the questionnaires, but various inductions may be made from the study of them as a whole.

1. The hospitals do not have a minimum standard of educational requirements for dietitians. Comparatively few instructors have had courses as student dietitians.

2. So far as the answers to the questions indicate the duties of the instructors are nearly uniform in each hospital.

3. The methods of instruction are very similar in all hospitals.

4. There are no definite years when classroom or laboratory work are given and these classes are often not concurrent. Classroom work usually precedes that given in the diet kitchen.

5. Most of the schools use a textbook for class instruction in dietetics. Fewer use a laboratory manual. An outline for the diet kitchen work is generally used.

6. The opportunity for giving work in the laboratory in preparing special diets, infant formulas, preparing diet lists, making menus and purchasing food supplies is not used to the extent which is easily possible by the laboratory classes.

7. Practically one-third of the instructors feel that the average nurse dislikes dietetics. The comments which are given may serve as very helpful constructive criticism.

Smile into the face of the world and a smile comes back; render a good service to others and good service is returned to you; show a spirit of helpfulness and that spirit will surely send back aid to you of a like kind; think good thoughts and the same good thoughts will be thought of you. The world is a great mirror which truly reflects the thoughts, acts and ambitions of every individual. Let no one cloud his vision, poison his mind and dwarf his soul with false imagination that the world is not giving him a square deal. The only way to avoid getting a square deal from the world is by not giving the world a square deal yourself.

HOW MANY TEASPOONS IN A ONE POUND CAN OF BAKING POWDER?*

IN AN effort to answer the oft asked questions: "Can you depend upon so-called measuring spoons for accurate results?" "Can you depend on them more than you can the ordinary type of teaspoon?" a considerable number of experiments were performed. We tried to get as many kinds of spoons as possible and found six different brands, all of which showed more or less variation as to capacity. Of the fourteen teaspoons tested, eight were of the aluminum sets containing one tablespoon, one teaspoon, one-half teaspoon and one-quarter teaspoon, linked together. These are commonly used in the home kitchen for measuring.

The volume of these spoons was determined by dipping the spoon into very fine sifted sand, leveling with the edge of a spatula and measuring that sand in a 10 cc. graduate. Sand was chosen for determing the volume because it would not pack on dropping from the spoon to the bottom of the graduate as much as baking powder would. All the measuring was done by one person in an effort to eliminate the personal element.

TABLE 1—VOLUME OF TEASPOONS USED FOR MEASURING

Number of Spoon	Volume	Variation from Theoretical as given by Bureau of Standards* (5 cc.)
1	4.3 cc. 4.3	-0.7cc
2	5.2 5.12	0.17
3	4.9 4.9	-0.1
4	4.8 4.85	-0.17
5	4.9 4.9	-0.1
6	4.7 4.7	-0.3
7	4.5 4.45	-0.5
8	4.9 4.9	-0.1
9	4.85 4.9	-0.12
10	5.0 4.95	0.00
11	4.9 4.9	-0.1
12	4.6 4.6	-0.4
13	4.9 4.92	-0.09
14	4.85 4.85	-0.15

*Circular of the Bureau of Standards No. 55, Measurements for the Household.

The average volume of a teaspoon from the twenty-eight samples measured was 4.8 cc.

The only variations which can be considered at all significant are those of teaspoons No. 1, No. 7, and possibly No. 12.

If we allow a variation of 10 per cent (.5 cc) above and below the standard we should have a variation of from 125 to 150 teaspoons in the one pound can of baking powder. These measurements assume an average weight of 3.3 grams for a 5 cc. teaspoon, levelful. (See Table 2 below).

TABLE 2—WEIGHT OF ONE MEASURING TEASPOON OF BAKING POWDER
(Teaspoon No. 10 of Table 1)

Number of Sample	Name	Date of Manufacture	Measured by A. P. Warren Weighed by Dr. Patten			
1	Bob White	July, 1919	3.480 g.	3.285 g.	3.370	3.376 g.
2	Crescent	June, 1919	3.385	3.260	3.405	3.350
3	Royal	Unknown	2.790	3.035	2.975	2.933
4	Ryzon	Unknown	2.935	2.875	2.735	2.848
5	Rumford Yeast P.	Unknown	3.725	3.595	3.685	3.668
6	Rumford	July. 1919	4.150	4.145	4.380	4.225
	Samples supplied to, or purchased for the experimental kitchen.					
1	Rumford	Unknown	3.955	3.815	3.710	3.823
2	Ryzon	Unknown		Cake—Discarded		
3	Bob White	Unknown	2.920	2.725	2.820	2.831
4	K. C.	Unknown	3.070	2.905	2.735	2.903
5	Calumet*	Unknown	4.060	3.905	3.810	3.925
6	Davis	Unknown	3.595	3.455	3.505	3.518
7	Calumet*	Unknown	....	3.740	3.700	3.720

Samples supplied by Bureau of Chemistry.
*Sample No. 5 of Calumet Baking Powder was measured in measuring spoon No. 10, which conforms to the Bureau of Standards Theoretical method. Sample No. 7 of the same baking powder was measured in William Rogers teaspoon.

The teaspoon of set No. 10 was used in Table 2, which shows the weight of one teaspoon. It will be observed that this was the only one of the fourteen which conformed precisely to the volume given by the Bureau of Standards (5 cc.).

Samples No. 5 and 7 of baking powder furnished by the Bureau of Chemistry illustrate the difference between measurements taken with the special spoon sold as a measuring spoon (Sample No. 5) and those taken with an ordinary teaspoon (Sample No. 7).

The samples were obtained by dipping the spoon into the can of baking powder, leveling with the edge of a spatula, and emptying into balanced watch glass on analytic as scale.

The measurements were all made by myself and all weighed by Dr. Patten of the Bureau of Chemistry. They all check fairly closely when taken on the same sample.

From the above data the average of those weighed on analytical balance (48 weighings, 12 samples, 8 brands) equals 3.3 grams (whether taken as the average of all the samples, or as the average of all averages for each brand). The variations seem to be as great among different samples of each brand, as among different brands.

A number of tests were made to determine the effect of personal equation, in manipulation, upon the amount of baking powder measured as one "standard" level teaspoon. Four trained laboratory workers took measurements on each of twelve samples of baking powder representing eight brands. These measurements were then weighed (though not on analytical balance), as were the amounts measured by myself. The differences due to per cent of the smallest amount measured, except in case of one sample where the range was 30 per cent. The variations due to manipulation of different persons with the same teaspoon are more numerous and greater than individual manipulation ranged from 10 per cent to 20 the variations due to differing capacities of different teaspoons.

*From Experimental Kitchen, Office of Home Economics, States Relations Service, U. S. Department of Agriculture, Washington, D. C.

Do three teaspoonfuls make one tablespoonful?

The statement that three teaspoonfuls make one tablespoonful is accurate enough for many practical purposes. But what is the range of variation as measured by careful weighing?

It might be supposed that in the manufacture of the aluminum sets sold for household measuring purposes, one would find conformity to the theoretical relation between the teaspoon and tablespoon; but the figures obtained below do not seem to substantiate that relationship.

For this comparison set No. 6, which consists of one tablespoon, one teaspoon, one-half teaspoon and one-fourth teaspoon made of aluminum and linked together, was used.

TABLE 3

Tablespoon from set No. 6—16.66 cc., or 3.54 times teaspoon No. 6.
One-half teaspoon from set No. 6—2.53 cc., or 0.57 times teaspoon No. 6 (instead of 0.5).
One-fourth teaspoon from set No. 6—1.15 cc., or 0.244 times teaspoon No. 6 (instead of 0.25).

Conclusions:

1. The weight of one teaspoonful of baking powder may be taken as 3.3 g. so far as these experiments are concerned.

2. It cannot be said that any one of these brands of powder gives a heavier or lighter teaspoonful than any other; but only that all brands vary a good deal among their different samples.

3. Teaspoons vary a little in size, occasionally. More important, however, are the variations in their manipulation by different persons, such as depth to which the spoon is dipped, manner of leveling, etc.

ARMY MEDICAL DEPARTMENT STUDIES SOURCES OF SUPPLIES

As part of a comprehensive study under the direction of the assistant secretary of war, the medical department of the army is undertaking a study of the sources from which the supplies which it procures and uses can be had. The medical department is not only concerned with the provision of the personnel necessary to the treatment of the sick, but is also charged with the supply of those things which are required by such personnel.

The armamentarium of modern medicine is exceedingly intricate, but without it the wonderful advances made in medicine are not available to the sick and injured, however skillful the personnel. The difficulties encountered in providing such elaborate equipment in time of war for the large number of new hospitals, infirmaries and first aid stations necessary, and particularly in providing it at those institutions in the advance area are manifest, and yet if the soldier is to be given the service to which he is entitled it must be provided.

In war of any magnitude the burden thrown upon industry for the production of these supplies is enormous. Any information that could be made available beforehand to industry as to type, number and quality, would obviously be of great advantage to industry in its plans. The surgeon general is therefore side by side with his plans for extension of the Officers' Reserve Corps and with his plans for instructing medical students through the R.O.T.C. in those duties of a medical officer which differ from those of the civilian physician, determining where the supplies needed by these officers may be had, should any grave emergency arise.

This effort is an attempt to do beforehand what was necessary after the declaration of war in the recent World War. It is done in recognition of the fact that the forces of the medical department, however numerous and skillful they may be, will be but half prepared without the necessary equipment. In brief, the program contemplates (1) that a careful determination shall be made, not only of the items needed, but of the quantity thereof. With a close liason established with industry, it is probable that often final decision as to the type of an article selected will be determined by the facilities of industry to produce it in large quantity. (2) The plan also contemplates a roster of personnel skilled in the manufacture, inspection and purchasing of the various commodity groups. It is desired to secure from industry itself, men who are eligible and will accept Reserve Corps commissions with a view to their assignment in time of emergency to the procurement of the commodity in which they are specialists. It is proposed that upon these men reliance will be placed in time of peace for advice and assistance in the study of industrial facilities and that in time of war they will be assigned to the centers of industry or to Washington for procurement duty. (3) The plan further contemplates that a thorough study be made of the facilities of the country to produce the essential and important items of the supply table and to have on file in the office of the surgeon general such reports as will enable the immediate placing of contracts in the event of any national emergency.

In this work the surgeon general realizes that he must rely upon industry itself, and it is hoped to secure definite and complete information from the manufacturers as to aid they can render. It is probable that in an emergency of any magnitude, Congress would again establish control of raw materials, labor, transportation and installations and the Medical Department expects that with the information to be obtained from the study on file, it will be in a position to render great assistance to the firms making medical department supplies. It can prevent the drafting of skilled labor, the taking of key men, it can assure the supply of material, of coal and of transportation and thus obviate difficulties in the operation of the plant.

"Let me do my work each day; and if the darkened hours of despair overcome me, may I not forget the strength that comforted me in the desolation of other times. May I still remember the bright hours that found me walking over the silent hills of my childhood, or dreaming on the margin of the quiet river, when a light glowed within me, and I promised my early God to have courage amid the tempests of the changing years. Spare me from bitterness and the sharp passions of unguarded moments. May I not forget that poverty and riches are of the spirit. Though the world know me not, may my thoughts and actions be such as shall keep me friendly with myself. Lift my eyes from the earth and let me not forget the uses of the stars. Forbid that I should judge others, lest I condemn myself. Let me not follow the clamor of the world, but walk calmly in my path. Give me a few friends who will love me for what I am; and keep ever burning before my vagrant steps the kindly light of hope. And though age and infirmity overtake me, and I come not within sight of the castle of my dreams, teach me still to be thankful for life and for times' olden memories that are good and sweet; and may the evening's twilight find me gentle still."—Max Ehrmann.

"Those who undertake such work (as nursing) must be not sentimental enthusiasts, but downright lovers of hard work."

OCCUPATIONAL THERAPY AND REHABILITATION

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SOME FALLACIES ABOUT THE REHABILITATION OF THE DISABLED SOLDIER

BY HERBERT J. HALL, M.D., PRESIDENT, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, MARBLEHEAD, MASS.

IN AN article published some time ago in the *Washington Post*, Brig. Gen. Charles E. Sawyer, physician to the President, outlines a "Hospitalization Ideal" and writes convincingly of a plan of centralization whereby in three or four large colonies he would have the disabled war veterans receive their medical treatment and an education which would fit them for actual service in the industrial world. He would remove the stigma of the asylum and the tuberculous sanatorium by having little or no separation of the insane, or the tuberculous, from the others and he would accompany medical treatment with vocational and academic training. He would have the men under treatment bring their families and build their own homes within the reservations; he would have agriculture and the trades taught practically and on the spot.

Favors Rehabilitation Centers

General Sawyer sees great evil in the specialized institutions scattered all over the country. His plan certainly has much to recommend it, however great might be the cost of scrapping the existing hospitals. There are to be sure certain serious objections, perhaps the most cogent being that so far large colonization schemes have been something of a failure. Men prefer to live in their own localities and do not take kindly to centralization. A complete separation of the really insane from the sane will surely be found necessary. An absolute isolation of the actively tuberculous is almost as desirable as the segregation of such communicable diseases as diphtheria and scarlet fever. However, it would be a wonderful thing for the soldier to go simply to a rehabilitation center and not to an asylum or a sanatorium; there is no denying that.

General Sawyer declared in his article: "To make such a plan workable it is quite important that every institution giving hospital care to the former soldier should have a well equipped and perfectly arranged special department in which vocational training can be carried on with an academic course as the underlying principle. It will then be quite easy to carry out a commercial course which would lead into all the practical lines of business affairs such as banking, accounting, etc. There should also be an industrial branch of the educational system which would give to every individual the opportunity to improve himself in any of the industries, such as carpentry, masonry, architecture, machine construction, machinery operation, etc."

Many Men Unfitted for Business

It is conceivable that a great centralization would produce better results in this direction that is now being accomplished in government hospitals all over the country. There is some doubt of this however. The fact is that a very large number of the disabled soldiers do not succeed very well in the study of business affairs, banking, accounting, and the like. There is a reason, and if they do not succeed in the smaller institutions why should they in proposed larger ones?

In one of the military hospitals during the war a course in stenography was advertised to begin on a certain date. A surprising number of applications were made for this course, fifty or more. When the class assembled, it was found that only a half dozen could read or write correct English. I am not "knocking" the American soldiers, far from it; they are a fine lot and worthy of every educational advantage we can give them, but we can hardly make bankers and architects out of them. It is said[1] that 1,700,000 drafted men were given psychological tests, and that seventy per cent of them showed an intelligence age of fifteen years. Forty-five per cent of the total number were morons, and of so low an intellectual capacity as not to be capable of self guidance. What does this mean? Only that the reëducation of the disabled soldier with few exceptions can be of a very elementary character only. Does it seem altogether wise to establish universities, or even elaborate business courses, for men who will never be able to progress beyond the grammar school grades?

There can be no doubt at all of the value and wisdom of careful training in the common school branches and the trades such as carpentry, electrical practice, masonry, blacksmithing, etc. This work is being done pretty well already in the existing government hospitals. It can be done much better as time goes on and with the equipment already at hand.

The proposed new system has little use for the diversional and curative occupations which have been so popular in the military hospitals during and since the war. General Sawyer's article goes on to say:

[1] Memoirs of National Academy of Sciences, Vol. xv., p. 99, Psychological Examining in U. S. Army. Edited by Robert M. Yerkes, Government Printing Office, 1921.

CASTLE

What Every User Knows

(The Hospital Superintendent and Surgical Nurse were talking—Series IV)

"Good morning, Doctor."

"*Morning, Miss Smith. I have been asked to recommend sterilizers for the new Maternity Hospital. What do you think of our Castle Sterilizers? You've used them long enough to know.*"

"They work perfectly, Doctor. I have used four standard makes in my sixteen years in hospitals and until I had this Castle outfit I never was absolutely certain of my work."

"*Yes, but you know, Miss Smith, these sterilizers are going into a new hospital—new nurses, new everything, and they may not have your kind of careful supervision. Do you know of any simpler kind?*"

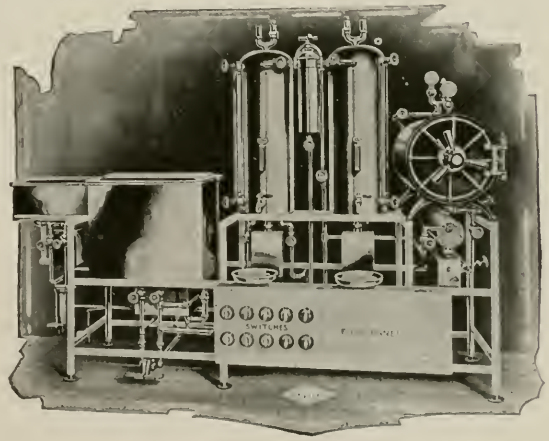
"That's just the point, Doctor. Our sterilizers serve us well because they are simple. The nurses know just what's going on and its hard to make a mistake."

"*That's good. But what about up-keep—repairs?*"

"That's another point, Doctor. We have never had any repairs made since they were put in, and they seem to be just as good as new."

"*Fine! Then I'll tell them that Castle sterilizers cost a little more, but I feel they are worth it. Thanks, Miss Smith.*"

Write for Castle sterilizer specifications



Castle Electric Sterilizer Battery installed in the Littleton Hospital, Littleton, New Hampshire.

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Makers of the largest line of Sterilizers for Hospitals, Laboratories, Physicians and Dentists

"A vocational training program which is carried out on a basis of entertainment and hospital occupation is unfair both to the world war veteran and to those who have the responsibility of operating such an institution. Bead and basket work and similar occupations have a place but certainly are not entitled to more than passing consideration in the attempt to rehabilitate soldiers" . . . . . "Let us study and work to make our boys strong and capable rather than effeminate and indifferent. Let us give them punch and determination rather than dependence and lack of character."

Now here lies, in the opinion of a good many whose views are worthy of respect, a very serious misapprehension which should not go unchallenged. Beyond the shadow of a doubt, we should give our disabled soldiers punch and determination rather than dependence and lack of character. But punch does not come to the slowly convalescent and the badly crippled man except by a very gradual process. The effeminate occupations, the bead work and the basketry referred to, have been of the very utmost service. A disabled man must walk before he can run, sometimes he must creep before he walks. It is also true that we may lead sometimes when we may not force or demand. The simple peasant crafts of hand weaving, toy making, basketry and the like will often appeal to the weakened convalescent when the heavier more exacting work of true vocational training seems, and is, wholly out of reach. It is the object of the so-called occupational therapy to interest the patient in some kind of objective work which is within his narrowed compass. Those who have had experience in this field know that such small occupations serve to strengthen and develop the weakened will, that they prepare the way for vocational training, for academic progress, or for any kind of independent life. It happens that a young women teacher trained in the art of occupational therapy and armed with diversional and developmental crafts work not infrequently gets at the good side of a man and "starts him going" when masculine authority, official though it may be, fails miserably.

It will not do to assume that the tuberculous, for instance, can during early convalescence undertake the same vigorous and constructive activities that are safe and proper for the constitutionally sound convalescent from gunshot wounds. Nothing but unwarrantable risk can accompany an attempt to force the issue. Even death is a possible result of too vigorous effort on the part of the consumptive patient. But no one doubts the value of light occupations such as basketry and bead work for such people. The occupational instructor, let it be repeated, often gets nearer than the doctor or the nurse to the heart of the convalescent, and is in a position through the practical help he gives, to save many a wrecked morale.

The hospital visitor has perhaps seen some husky exdoughboy stringing beads and has said, "This is absurd, such a man should be doing something worth while, he should be preparing himself for real real work in the world; enough of this foolishness." Well, the surgeons in the base hospitals in France said and thought the same thing until they came to realize that these "foolish occupations" changed the wards from serious demoralization to hopefulness and order. By all means, graduate as soon as possible to the more manly and vigorous vocational training, but let us be sure first that the patient *can* so change and let us not minimize the importance of the thin wedge that opens the way. Is it surprising that the amusing occupation of basketry, toy making and the like should have a real place in the development and progression of men who possess to begin with only the intellect and capacity of children?

We may not without danger to the success of the whole system of rehabilitation throw aside or ignore these wholesome, developmental crafts. If we are to have established new reconstruction centers, they should be strong in the small arts which stimulate interest and develop ability to sustain effort of any kind and so make possible the higher grades of reeducation.

The nation has an unprecedented chance to reeducate and to improve the industrial and intellectual possibilities of sick and disabled soldiers. There is no more appealing or more practical service. Money spent for such purposes, however great the amount, could find no better moral or economic use. But may it not be wise to pause and consider well before we discard our entire military hospital system? Perhaps after all, the old shears may be made to cut. Perhaps the old service may be quickened and developed to a point of full efficiency.

Brig. Gen. Sawyer, the president's physician, wants the disabled ex-service man given "punch and determination," which characteristics in his opinion are not developed by bead and basket work. The brigadier general is quoted as saying that the small arts are not entitled to more than passing consideration in the attempt to rehabilitate soldiers and that their tendency is to foster a dependent and effeminate spirit among the men.

In the accompanying article, Dr. Herbert J. Hall points out what seems to him the essential and rightful place of the arts and crafts in rehabilitating the former soldier. Not only have intelligence ratings disclosed that the average ex-service man is mentally unfitted for the skilled and professional studies General Sawyer would have him undertake, but his physical condition is frequently such that immediate application to strenuous study would be harmful and even fatal, Dr. Hall believes. As a stepping stone to vocational training, not to mention its value in maintaining the former soldier's morale, Dr. Hall sees justification and need for occupational therapy work in government reconstruction hospitals.

STATE APPOINTS O. T. FIELD WORKER

The department of public welfare of Pennsylvania has taken a most progressive step in appointing a field representative in occupational therapy. The following announcement is made of the appointment:

"Recognizing the importance of occupational therapy in hospitals for mental diseases, the bureau of mental health of the Pennsylvania department of public welfare has established the position of field representative in occupational therapy. Miss Mary L. Putman, who has had experience in numerous states and institutions of various kinds has been appointed to this position. Several mental hospitals in Pennsylvania have very excellent occupational activities going on and it is expected that through Miss Putman's efforts, such facilities will be extended throughout the state. Miss Putman will first conduct a survey of

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Hospital Size

KNOX Sparkling Gelatine—the Standard of Purity for over thirty years—is now packed in one and five-pound cartons.

This has been made necessary by the constantly increasing number of hospitals which have recognized the dietary value of KNOX SPARKLING GELATINE—not only as a protein sparer, but as a most appetizing conveyor of other nutritious foods.

Eminent authorities find great value in the use of KNOX SPARKLING GELATINE for desserts and salads in the diet of the sick and convalescent, and also the raw egg diet, also in milk for infants and adults because of a greater absorption of the milk and for preventing digestive disorders from the non-emulsification of the fat masses. Our books contain recipes for all these uses.

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the various institutions as to the scope of their occupational activities. She will also be available for consultation and organization of occupational activities in the various other institutions under the supervision of the department of public welfare."

Miss Putman has been in the work a long time and has many friends throughout the country who are rejoicing in this recognition of her splendid understanding of mental patients and are appreciating the new lines of service which are open to her ministrations.—E. U. D.

THE ROLL CALL

Institutions Having Occupational Therapy

ILLINOIS.

Chicago Tuberculosis Sanitarium.
Chicago State Hospital.
Children's Memorial Hospital.
Cook County Hospital.
Cook County Psychopathic Hospital.
Home for Destitute Crippled Children.
Michael Reese Hospital.
Presbyterian Hospital.
St. Luke's Hospital.
U. S. Marine Hospital No. 5.
U. S. Veterans Hospital No. 30.
U. S. Veterans Hospital No. 30 Annex.
U. S. Veterans Hospital No. 76.
Wesley Memorial Hospital.
Improvement Association for Blind People.
The Spaulding School.
The Vocational Society for Shut-Ins has occupational therapy centers. A number of private hospitals, public institutions and state insane hospitals also have occupational therapy.

MANITOBA.

Winnipeg.
Manitoba Military Hospital.
Psychopathic Hospital.
Military Wing of General Hospital.
Military Wing of St. Boniface Hospital.
Deer Lodge Convalescent Home.

Selkirk.
Mental Hospital.

Brandon.
Mental Hospital.

Ninette.
Manitoba Sanatorium.

Portage la Prairie.
School for Feeble-Minded.

MARYLAND.

Sheppard & Enoch Pratt Hospital, Towson.
Phipps Psychiatric Clinic, Care of Johns Hopkins Hospital, Baltimore.
Spring Grove State Hospital, Catonsville.
Springfield State Hospital, Sykesville.
Crownsville State Hospital for Colored Insane, Crownsville.
Rosewood Training School, Owings Mills.
Dr. Barker's Nursing Homes, Baltimore.
University of Maryland Hospital, Baltimore.
Union Memorial Hospital, Baltimore.
Johns Hopkins Hospital, Baltimore.

MASSACHUSETTS.

General Hospitals.
Massachusetts General.
U. S. Marine No. 2.
U. S. Veteran's Hospital No. 36
U. S. Naval Hospital, Chelsea.
Children's Island Sanitarium.
Union Hospital, Fall River.
Beverly Hospital, Beverly.
Memorial Hospital, Worcester.

Tuberculosis Hospitals.
Boston Sanatorium.
Bay View, Fall River.
Plymouth County Hospital.
Tuberculosis Hospital, Pittsfield.

Mental Hospitals.
Boston Psychopathic Hospital.
Medfield State Hospital.
Boston State Hospital.
Northampton State.
Worcester State.
Gardner State Colony.
Grafton State.
U. S. Veteran's Hospital No. 44.
McLean Hospital, Waverly.
Channing Sanitarium.
Adams Nervine.
Woodside Cottages.
Glenside Hospital.
Devereux Mansion.
Dr. Rigg's Sanitarium, Stockbridge.

MICHIGAN.

Detroit Tuberculosis Sanatorium, Detroit.
Receiving Hospital, Detroit.
Ex-Service Men's Dept. Detroit T.B. Sanatorium, Detroit (Red Cross.)
U. S. Marine Hospital, Detroit.
Grace Hospital, Detroit.
Michigan Mutual Hospital, Detroit.
Herman Kieffer Hospital, Detroit (temporarily discontinued).
Children's Free Hospital, Detroit. (This work has been done through Red Cross and is volunteer work).
Detention House Juvenile Court, Detroit.
House Correction, Detroit.
Homeopathic Hospital, Ann Arbor.
Psychopathic Hospital, Ann Arbor.
Kalamazoo State Hospital, Kalamazoo.
Wayne County Insane Asylum, Eloise.
Battle Creek Sanitarium, Battle Creek.
Michigan School for Crippled Children, Farmington.
Eight departments for blind under Board of Education, Detroit.

MISSOURI.

Junior League Workshop, Barnes Hospital (for Washington University Dispensary Out-patients), St. Louis.
Barnes Hospital (Ward work conducted by Missouri Ass't for Occupational Therapy), St. Louis.
St. Louis City Hospital, St. Louis.
St. Louis City Sanitarium, St. Louis.
St. Louis Children's Hospital, St. Louis.
U. S. Marine Hospital, St. Louis.
U. S. Veterans' Hospital No. 35, St. Louis.
M.A.O.T. Shop for Handicapped, St. Louis.

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"America's Most Famous Dessert"

JELL-O

AMERICA'S MOST FAMOUS DESSERT
JELL-O
A MIXTURE
SPECIAL PACKAGE
MAKES FOUR QUARTS
RASPBERRY
PURE FRUIT FLAVOR
VEGETABLE COLOR
This package makes four quarts of Jell-O. Serves forty to fifty persons according to size of portion.
Dissolve the contents of the package in four quarts of boiling water and set in a cold place to harden.
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GALLON SIZE

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Red Cross Workshop, Jefferson Barracks.
Robert Koch Hospital, Koch.
Jewish Sanitarium, Anglum.
Missouri State Sanatorium, Mt. Vernon.
State Hospital No. 1, Fulton.
State Hospital No. 4, Farmington.
Home for Aged and Infirm Israelites, St. Louis.
Mt. St. Rose Hospital, St. Louis.
State Hospital No. 2, St. Joseph.
State Hospital No. 3, Nevada.

NEW YORK.

Montefiore Hospital (Chronic).
Montefiori County Sanitarium.
11 county sanatoriums.
Bellevue General Hospital.
Sea View Hospital (Tuberculosis).
Randall's Island—Children (F. W.).
Hudson Hospital.
Neurological Hospital.
Vanderbilt Clinic.
Reconstruction Hospital.
St. Luke's Hospital.
Presbyterian Hospital.
Bloomingdale Hospital (mental—private).
5 private mental sanitariums.
Veterans Bureau Hospitals.
Trudeau Sanatorium.
4 private sanatoriums.

State Hospitals.

Brooklyn State Hospital, Brooklyn.
Buffalo State Hospital, Buffalo.
Central Islip State Hospital, Central Islip.
Gowanda State Homeopathic Hospital, Collins.
Hudson River State Hospital, Poughkeepsie.
Kings Park State Hospital, Kings Park.
Manhattan State Hospital, Ward's Island, New York City.
Middletown State Homeopathic Hospital, Middletown.
Rochester State Hospital, Rochester.
St. Lawrence State Hospital, Ogdensburg.
Utica State Hospital, Utica.
Willard State Hospital, Willard.

ONTARIO.

Christie Street Hospital, Toronto, Dept. of Soldiers' Civil Re-Establishment.
Euclid Hall Hospital, Toronto, Dept. of Soldiers' Civil Re-Establishment.
Brant Hospital, Burlington, Dept. of Soldiers' Civil Re-Establishment.
Mountain Sanatorium, Hamilton, Dept. of Soldiers' Civil Re-Establishment.
Muskoka Cottage Sanatorium, Gravenhurst, Dept. of Soldiers' Civil Re-Establishment.
Calydor Sanatorium, Dept. of Soldiers' Civil Re-Establishment.
Social Service Dept. Toronto & Hamilton, Dept. of Soldiers' Civil Re-Establishment.
Westminster Psychopathic Hospital, London, Dept. of Soldiers' Civil Re-Establishment.
Byron Sanatorium, London, Dept. of Soldiers' Civil Re-Establishment.
Sydenham Hospital, Kingston, Dept. of Soldiers' Civil Re-Establishment.
Mowal Sanatorium, Kingston, Dept. of Soldiers' Civil Re-Establishment.
Toronto General Hospital.
Toronto Free Hospital for Consumptives.
Industrial Home for Girls, Toronto.
Homewood Sanatorium, Guilph.
Hamilton General Hospital.
Ontario Hospital for Mental Diseases, Toronto.
Ontario Hospital for Mental Diseases, Hamilton.
Ontario Hospital for Mental Diseases, Whitby.
Rockwood Asylum, Kingston.

PENNSYLVANIA.

Philadelphia.

Philadelphia General Hospital.
Philadelphia Hospital for Mental Diseases.
Pennsylvania Hospital.
Pennsylvania Hospital, Department for Mental and Nervous Diseases.
University Hospital.
Jewish Hospital.
Friends' Hospital.
Children's Hospital.
Jefferson Hospital (Children).
Jefferson Hospital (Convalescent Home for Men).
The Browns' Farm (Orthopedic).
Phipp's Institute.
Home for Incurables.
Visiting Nurse Society.
American Red Cross (Navy Yard).
Public Health Hospital No. 49.

State.

Allentown State Homeopathic Hospital.
Pennsylvania State Sanatoriums at Hamburg, Cresson, and Mont Alto.
Harrisburg State Hospital, Harrisburg, Pa.

WASHINGTON, D. C.

Walter Reed Hospital, U. S. A. General Hospital.
St. Elizabeth's Government Hospital for the Insane.
McAlto Veterans' Bureau.
Tuberculosis Hospital.
Public Health Service, U. S.

WISCONSIN.

General Hospitals.

Columbia Hospital, Milwaukee.
Milwaukee Children's Hospital.
Mt. Sinai Hospital, Milwaukee.
Bradley Memorial Hospital, Madison.

Psychiatric Institutions.

The Milwaukee Sanitarium, Wauwatosa.
Milwaukee County Hospital for Mental Diseases.
Oconomowoc Health Resort, Oconomowoc.
U. S. Public Health Service Hospital No. 37 (Resthaven), Waukesha.
Wisconsin Psychiatric Institute, Mendota.
Riverside Sanitarium, Milwaukee.

Tuberculosis Sanatoriums.

Muirdale Sanatorium, Wauwatosa.
Statesan Sanatorium, Statesan.
Mt. Washington Sanatorium, Eau Claire.
Oaks Sanatorium, Pawaukee.
Maple Crest Sanatorium, Whitelaw.
Mount View Sanatorium, Wausau.
Riverview Sanatorium, Little Chute.
Sunny View, Winnebago.
River Pines, Stevens Point.
Hickory Grove, West De Pere.
Sunny Rest, Racine.
Willow Brook, Kenosha.
Pureair, Bayfield.
Oak Forest, La Crosse.

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Pillsbury's Wheat Cereal

AS you know, there is no finer body-building food than farina, the rich, meaty heart of the wheat. Pillsbury's Wheat Cereal is pure farina, and because it comes from scientifically selected wheat, cleanly and carefully milled, it is of unusually high quality.

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Because of its uniform granulation, Pillsbury's Wheat Cereal does not lump in cooking. It makes delicious, *smooth,* creamy porridge, gruel or puddings.

We take pleasure in sending physicians a package to try, upon request.

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Pillsbury's Family of Foods
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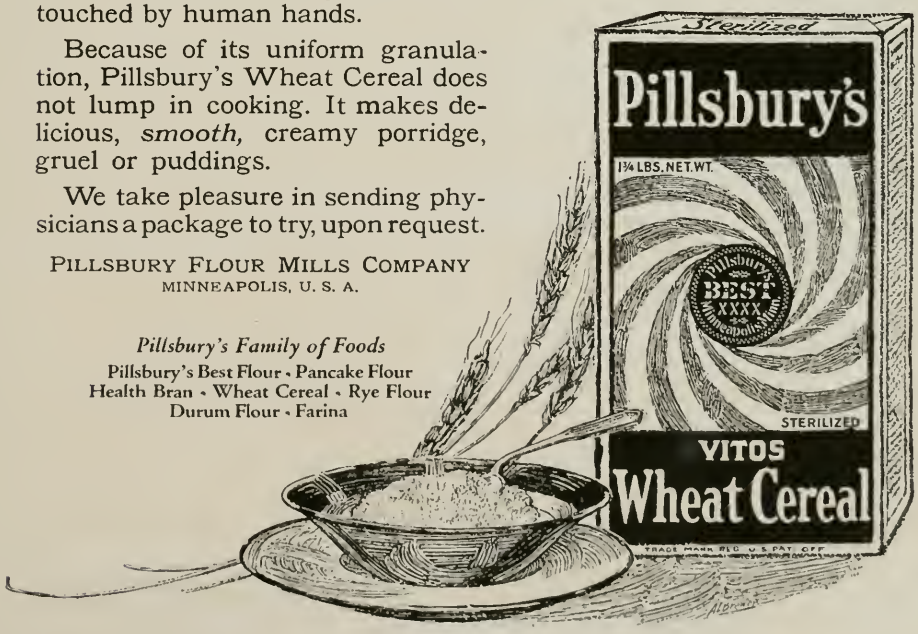
Durum Flour • Farina



DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

SURVEY SHOWS NEED FOR FOLLOW-UP WORK IN EYE CLINICS

(From the ASSOCIATED OUT-PATIENT CLINICS of the City of New York.)

A COMMITTEE of leading ophthalmologists of the city of New York, organized as the ophthalmological section of the Associated Out-Patient Clinics, has instituted a number of studies of eye clinics, with a view to ascertaining present conditions and developing desirable standards. Some material on the timely and important subject of follow-up seemed worthy of publication in advance of the complete report and findings of the section.

Dr. Walter E. Lambert is chairman of the committee, and Dr. Conrad Behrens Jr., secretary. The study was made under the supervision of the committee by Dr. Gertrude E. Sturges and Miss Elizabeth Tandy of the staff of the Associated Out-Patient Clinics.

Although medical science has progressed far in the development of methods of treatment for diseases of the eye, it is common knowledge that much preventable blindness exists. Typical cases of eye diseases which may lead to blindness, unless properly cared for, are constantly visiting the various clinics. To discover the proportion of these conditions in the ordinary intake of the clinic, and the care and disposition of these cases by the clinic, a study was made of 5,200 records from five representative eye clinics in New York: Cornell Clinic; Manhattan Eye, Ear and Throat Hospital; Mount Sinai Hospital; New York Eye and Ear Hospital; and New York Post-Graduate Hospital. To allow for sufficient time to have elapsed for the clinic to have disposed satisfactorily of the cases, records of patients who had visited the clinic for the first time at least one year previous to the date of the inquiry were studied. Special attention was given to cases of nineteen selected diseases which may lead to blindness. The list is given toward the close of this article.

Records Are Not Uniform

There is no uniformity in the handling of records and the recording of data in the various clinics. In three, return visits of patients are automatically stamped on their records, and in the other two no notation is made unless the physician happens to record progress notes. In the clinics where automatic stamping is customary, the average number of visits for patients was apparently higher than in the other two. Two dispensaries have central filing systems; medical records are filed in the clinics in the other instances. In none of the five clinics are progress notes consistently recorded. It is customary to enter only the examinations made at the initial visit and medication or treatment; the progress and ultimate disposition of the care are left to the imagination of the research worker.

One hundred and ninety-three, or 3.7 per cent of the 5,200 records fell into this group of selected diseases. There were 34 cases each of keratitis and trachoma, 31 of iritis, 29 of corneal ulcer, 21 of glaucoma, 15 of optic atrophy, 10 of retinitis, six each of purulent conjunctivitis and uveitis, five of choroiditis, one each of ophthalmia and retrobulbar neuritis.

For the reason that diagnoses were often illegible or incomplete, these numbers probably do not represent an accurate cross section of the dispensary intake of these conditions.

Patients Fail to Return to Clinic

The study of these records brings out clearly the failure of patients to attend clinic a sufficient number of times to alleviate the eye conditions or to prevent spread of contagion. One hundred and three of the 193 cases presenting the selected eye conditions are recorded as attending clinic once, 22 attended twice, 38 attended from three to five times, 15 attended from five to ten times, 10 attended from 10 to 20 times, five attended over 20 times. Of the cases with these serious eye conditions which might bring on permanent blindness, 53.4 per cent attended the clinic only one time. Only 15.5 per cent attended more than five times.

The same point is brought out still more forcibly in the instances of certain especially serious diseases. Eighty-three per cent of the cases of purulent conjunctivitis, 80 per cent of the cases of syphilitic retinitis, 75 per cent of the tubercular keratitis, 69 per cent of corneal ulcer attended clinic only once. Eighty-one per cent of the cases of glaucoma made three visits or less. None of the cases of retinitis, optic atrophy or purulent conjunctivitis made more than three visits.

The clinic clearly assumes some responsibility for its patients. That such a large proportion of patients presenting eye conditions which may lead to blindness and the accompanying financial disability does not return for treatment is a stigma of failure on the part of the clinic to assume this responsibility that the administrative and medical authorities can scarcely face with equanimity.

The records showed slight evidence of any attempt

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"The Taste Delightful"

Gelatine contains 91.4% protein. It is easily soluble and perfectly digestible.

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Modern hospitals are using much gelatine, and a prominent physician says: "They should use a great deal more."

Gelatine is definitely supplemental to medical treatment, and is an integral part of hospital diet.

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All our goods are always pure and fresh.
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Packages of sizes convenient for institutions.

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409-411 WEST HURON ST., CHICAGO, ILL.

1922

to insure proper care to the patient beyond the filling of prescriptions for drugs and glasses, and very little appreciation of the need to protect other members of society from infection. One socially minded physician recorded the fact that in the family of a trachoma patient who attended clinic twice, there were two other children infected with the same disease. The record shows no attempt to have been made to bring the other members of the family under care, or to insure the cure of the original case. There was no evidence of any effort to bring tuberculous cases under proper hygienic conditions. In the syphilitic group laxity was also evident. While it is customary to take Wassermanns it is by no means a universal practice. The following figures show to some extent the failure of the clinics to take advantage of the Wassermann reaction as a diagnostic procedure in the cases of eye conditions which may be caused by syphilis. (Iritis, interstitial keratitis, retinitis, etc.) Of the 79 such cases found in this study, only 36 were given this test, and of these, the results were negative in 17; doubtful in one, positive in 10 and not recorded in eight. Further, the records examined failed to show that the clinics brought the patient who showed a positive reaction under arsphenamin treatment. There was evidence in the record of the provision of proper care for only four out of the ten cases for whom a positive Wassermann report was received.

Some Attempts at Follow-up

The Massachusetts Charitable Eye and Ear Infirmary has demonstrated that it is possible for a dispensary to conduct a systematic follow-up of such cases. At this institution intensive work has been done for classes of phlyctenular keratitis and interstitial keratitis. Not only has the proper medical care been provided, but the cases have been brought under hygienic living conditions and the examination and necessary treatment of other members of the family provided for. A systematic follow-up of other special conditions is also conducted, resulting in the satisfactory control of a large majority of cases until the completion of treatment, and providing a valuable mass of data for research.

The New York State Commission for the Blind has done some pioneer work in the city of New York along these lines through two follow-up workers, one in the Manhattan Eye, Ear and Throat Hospital, and one in the Brooklyn Eye and Ear Hospital. Obviously it is not possible for one individual to handle the follow-up work that should be done in an institution of this size and in neither institution has a systematic follow-up of all cases been installed. However, recognition should be given to the splendid effort which this organization has made.

Recommendations of Ophthalmologists

On the basis of these findings the committee of ophthalmologists has adopted the following recommendations:

"Systematic follow-up to insure continued treatment for at least the following types of cases should be instituted:

Atrophy, optic
Conjunctivitis (purulent)
Choroiditis (tubercular)
Corneal ulcers
Glaucoma
Iritis
Keratitis, interstitial
Keratitis, phlyctenular
Keratitis, tubercular
Neuritis, retrobulbar
Ophthalmia, sympathetic
Papillitis
Papilloedema
Retinitis, diabetic
Retinitis, pigmentosa
Retinitis, syphilitic
Sarcoma of the choroid
Trachoma
Uveitis

"Physicians should be responsible for seeing that the patient is informed of the nature of the trouble and the importance of treatment, and for deciding on what date the patient should return.

"The social service department with such clerical assistance as is necessary should note the name of the patient whose return is desired and through the proper methods endeavor to secure his return at the date specified."

STATISTICS SHOW DECLINE IN DEATH RATE FOR VENEREAL DISEASES*

Figures for industrial policy-holders of the Metropolitan Life Insurance Company during the last four years show a decrease in mortality rates for the venereal diseases. Since 1917 the rate for syphilis, locomotor ataxia and general paralysis of the insane has declined 21 per cent, the figure for 1921 being 13.1 per 100,000 as compared with 16.6 in the earlier year. It is interesting to note that while there was a considerable increase each year from 1911 to 1917, there has been a sharp drop since then. This change is even more significant in view of the fact that reporting is more accurate on death certificates. The decline, therefore, has been accomplished in spite of better reporting. The decline seems to be most decided in the case of syphilis rather than for locomotor ataxia. The figures indicate that the difference between the rates for 1917 and for 1921 is chiefly accounted for by the lowering of the rates in the age period between 25 and 55 years. This improvement may be due to improved methods of treating syphilis as well as the various measures of control established during the war by private agencies acting in cooperation with the government.

VENEREAL DISEASE DATA

It is interesting to note the definite progress that is being made in the accumulation of data on the venereal diseases. The Division of Venereal Diseases of the Bureau of Public Health Service calls attention to the following outstanding facts among the reports received recently:

Of 487 reports received during the quarter ending May 31, 1921, in almost every instance the reports came from sources receiving state aid. Of the total number receiving state aid, sixteen clinics failed to report. Four hundred and nineteen reports were from clinics, and sixty-eight were from detention homes, hospitals for the insane, penal institutions, general hospitals, and some clinics receiving no aid from the state in which they are located.

One state, whose combined report counted as one among the 487 sources, has twelve regular clinics and seventy "cooperative clinics." Each of the cooperative clinics consists of a private physician, specially trained in one of the state clinics, who treats indigent cases free in return for having a minimum of equipment and all drugs furnished by the state. Another state conducts three "treatment centers" on a similar basis; but these are not reporting at present. Both Florida and Michigan have a traveling clinic.

During the quarter, eleven clinics were closed, and fourteen new clinics were established, nine of which have already begun to report.

The Service hopes to receive reports from more than five hundred sources in the near future; and it is urging prompt reporting from every state venereal disease control officer.

*Abstract Service, American Social Hygiene Association.

Adv. page 58

Is Mineral Starvation a Primary Cause of Disease?

PHYSIOLOGISTS now generally concede that a demineralized diet reduces the supply of vital energy, and helps prepare a tissue-soil favorable to the growth of pathogenic germs.

Since mineral deprivation may be considered an actual cause of disease, Grape-Nuts is valuable in conditions of mal-nutrition resulting from demineralized foods.

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In fact, the qualitative tests of the self-developed sugar in Grape-Nuts indicate this food contains a notable proportion of dextrose—the end product of carbohydrate conversion.

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FOREIGN CORRESPONDENCE

SHARP DIFFERENCES OF OPINION MARK ANNUAL CONGRESS OF BRITISH MEDICAL ASSOCIATION

(From Our London Correspondent.)

AT THE Congress of the British Medical Association which opened on July 21 last at Glasgow with the meeting of the Representatives, the question of the voluntary hospitals was once again fully discussed. The views of those present were extremely conflicting, some holding that the voluntary system should be continued with certain modifications, while others insisted that the system was as dead as Queen Anne and that a system more in conformity with the changed conditions should be thought out and substituted for it.

Mr. Bishop Harman, chairman of the Hospitals Committee, gave it as his opinion that the voluntary hospitals which were started as charitable institutions would go the way of the old educational institutions which had been founded for poor boys but had become the big public schools of the country to which doctors and others now paid handsome fees for their own boys. He thought that the time would come when the state would have made such complete provision for the indigent that the poor would not need to go to the voluntary hospitals, which would then become the place for those who said: "I am willing to pay for my own treatment and maintenance and prefer to have it under private enterprise rather than under state provision."

195 Motions of Policy Before Body

The British Medical Association had to legislate in view of that possibility. There were 195 motions and amendments dealing with hospital policy on the agenda, and the representative body, meeting at 9:30 devoted the whole of the day to their consideration. The discussion verged on the acrimonious and at any rate was distinctly lively. It revealed sharp cleavage of opinion, especially on the dominant question as to whether hospital doctors should be paid a proportion of the money charged by the hospitals in respect of insured or better class patients. With one exception which touched the latter question, the principal motions submitted by the council were carried. They declared *inter alia* that—"The Association recognizes a dual policy as regards the voluntary hospitals: (a) That the purely charitable side should be continued, wherein the whole cost of the main admission of indigent patients is met by the gratuitous contributions received by the hospitals and on whose behalf the services of the honorary medical staffs are given gratuitously; (b) That other patients, who are not indigent, may be received for treatment at voluntary hospitals when adequate treatment cannot be obtained elsewhere, and that for them payments should be received by the hospitals either from the patients themselves or, on their behalf, from the authority or body referring them to the hospital and that on account of their treatment some method of remuneration of the honorary medical staff be arranged."

When he submitted this statement of policy Mr. Bishop Harman said that the profession would gladly continue to give its services "free, gratis and for nothing" to those who were properly entitled to charity. He said: "We are not afraid to speak of charity; it is the finest word in the English language, and we are not going to down it because it is unpopular in certain circles." When the council's report on the whole question was presented for approval, the note of opposition was disclosed, an amendment being put forward declaring it to be unwise to adopt the policy suggested, as it would alter the present status of the medical staff in a manner detrimental to the interest of the profession.

"Aristocracy of Profession" Threatened

Dr. Macfayden in urging the amendment said the profession would suffer politically, economically and in the public estimation if the proposals as a whole came into effect. The medical staff of a voluntary hospital was the aristocracy of the profession in a town, and its members did not want their aristocracy mixed up in money questions. "We do not want the sale of honors in our profession," he said; "we want to maintain the election of staffs purely on the ground of merit and talent and service to the community."

With the money question came the prospect of state interference and lay control. Dr. Rees declared that the voluntary principle of finance in hospitals had broken down. It was inefficient, uneconomical and unfair. Dr. H. S. Souttar said the voluntary system in the old sense was absolutely dead. After all why should they be run entirely on voluntary lines, for "the poor are no longer with us." The amendment was defeated.

Regarding the payment of hospital staffs, Dr. G. E. Haslip, treasurer of the association, said: "We do not call ourselves honorary medical practitioners. We are medical practitioners out for a livelihood." He pointed out that as

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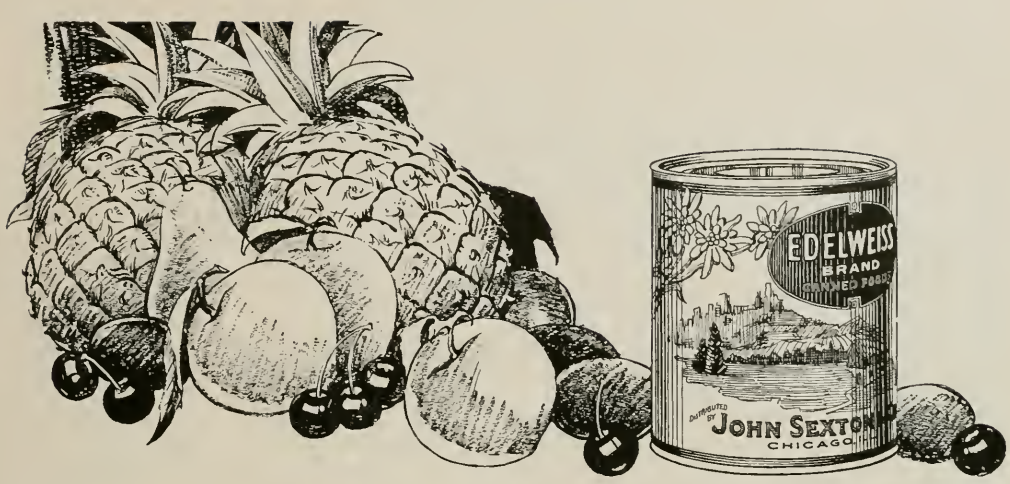

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As the largest distributors of No. 10 canned goods, our booths (64 and 65) at the American Hospital Convention and (163-166) at the National Restaurant Association Convention are always the center of interest.

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the discussion proceeded on the various motions and amendments it demonstrated a deep cleavage of opinion, even among those who supported the formation of hospital staff funds, as to the sources from which these funds were to come. The council recommended that a percentage of all payments whether state aided, rate aided, or private patients' payments, should pass into a fund to be at the disposal of the honorary medical staff. This drew an amendment from Dr. Brackenbury excluding from the motion gratuitous payments by private patients except where these exceeded the cost of maintenance and accommodation. The amendment was carried.

The conflict of opinion was so marked that Mr. Harman withdrew the original motion dealing with the formation of hospital staff funds and put a new proposal in its place to the effect that "the council be instructed to reconsider the terms of the present policy of the association and report what, if any, modifications might be desirable to meet any possible inequities that might arise from its operation." The new proposal was carried on the understanding that Dr. Brackenbury's and other views would be considered by the council. The conference, however, passed the following declaration, recommended by the council:

"Voluntary Administration Advantage to Public"

"In view of the tendency of the state, through local and central authorities, to require the services of the voluntary hospitals, it should be provided that in any arrangement for such services the state should pay a full cost to the hospital so that no portion should be charged to the charitable funds of the hospital, and that the payment so made should include an amount for the remuneration of the honorary medical staff of the hospital." The conference also assented to a declaration that the voluntary method of administration of the voluntary hospitals was to the advantage of the public, medical service and the medical profession and should be retained.

As for the payment of staff a further amended paragraph was passed, the discussion of which led to an examination and re-examination of the arguments for the payment of hospital staffs:—When the board of management of a voluntary hospital enters into a financial arrangement with a public authority, an employer of labor, approved society, insurance company, or under a contributory scheme or otherwise for the reception of patients, such arrangement should be taken to cover the cost of maintenance and treatment and a percentage of all such receipts should be passed into a fund which is at the disposal of the honorary medical staff of that hospital. There followed a lengthy debate upon the definition of a voluntary hospital, some of the definitions proffered were of a quaint and humorous nature.

The definition of the Representative Body was as follows: The association maintains that the essence of the voluntary hospital system is the independent and voluntary management, and that this is not necessarily related to the conditions of service of the medical staff.

In connection with a staff fund the following resolutions have been passed as the result of a conference between representatives of the medical staffs of the following London teaching hospitals: St. Bartholomew's, Guy's, King's College, St. Mary's, Middlesex, St. Thomas', University College, Westminster and the Royal Free.

Resolutions on Staff Fund

1. That under present conditions in the case of patients who contribute towards but pay not more than the whole cost of their maintenance in a voluntary hospital, it is undesirable that any portion of such contribution should be allotted to a staff fund. Adopted with no dissentient.

2. That when the state, a municipal or other public body pays toward the accommodation, maintenance and treatment of a patient or group of patients, in a voluntary hospital, a percentage of such moneys should be allocated to a staff fund. Adopted with Guy's, Middlesex and University College dissenting.

3. That when a special clinic is held by a member of a hospital staff for the treatment of patients sent by the state, a municipal or other public body, the member of the staff taking such a clinic should be adequately paid. Adopted with Guy's dissenting.

It really seems that there is too much talk and too little action with regard to the hospitals of Great Britain. It is notorious that the hospitals in every part of this country are in a deplorable financial situation and this is especially the case with those of London. Moreover, they have been in the dilemma for some time and day by day getting more deeply involved. The profession does not wish for state or municipal control because if either of these alternatives come to pass, its members will lose a great deal of their independence, a possibility which greatly alarms them. On the other hand, some definite steps to relieve the situation must be taken soon. As has been suggested on several occasions in these columns, the most reasonable way out of the difficulty would appear to be the adoption of the pay or partial pay system.

ROTARY CLINIC ACHIEVES RESULTS

Some achievements of the Vancouver (B. C.) Rotary Clinic in its first three years of operation are listed in its third annual report recently issued. The clinic does diagnostic work, provides treatment in the building and on the verandas for incipient cases of tuberculosis, carries on preventive work through a fresh air school and summer camp and sends out much educational propaganda.

Since the opening of the clinic, it has had 5,382 consultations and 2,479 new patients. More than 100 former patients are now earning a living for themselves. The wages of these former patients, the report declares, would pay for the maintenance of several such clinics.

The Vancouver Rotary Clinic, although now operated under a civic grant, was founded by the Rotary Club of the British Columbia city when its attention was called to the need for an "independent separate building for diagnostic purposes, for the treatment of incipient forms of tuberculosis and for a place where all forms of tuberculosis work might be coordinated." With such a clearing house as its goal, the organization pledged $18,000 and in a four-day campaign obtained an additional $60,000 by public subscription. A building was erected, equipped and operated for one year by the Rotary club, after which it was presented to the city of Vancouver. The Rotary Club still provides funds for visiting nurses to aid in the work.

NURSE IS DECORATED BY FRANCE

Miss F. Elisabeth Crowell, R.N., director of nursing service of the Rockefeller Commission for the Prevention of Tuberculosis in France, was recently decorated by President Millerand. Miss Crowell was formerly executive secretary of the Association of Tuberculosis Clinics in the city of New York. The French president pinned the insignia of the Legion of Honor on Miss Crowell at a presidential reception to members of the Commission when it terminated its active work in France.

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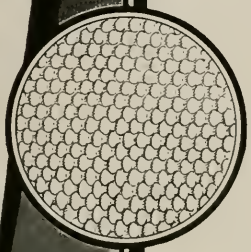

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Hints to Hospital Superintendents

EDUCATING HOSPITAL TRUSTEES

Hospital superintendents should endeavor to educate their boards of trustees in institutional administration and to this end the following suggestions may be of assistance:

1. One or two of the members of the board of trustees should be appointed each month to make a complete survey of the institution and report their findings at the monthly meeting. When they make this tour of the hospital it would be better if they were unaccompanied by any official. They could consult with an official when the tour was complete.

2. Hospital trustees should be encouraged to read consistently a good hospital magazine.

3. The board of trustees should be given a monthly report of the medical work of the hospital so that they may more fully realize their responsibility as institutional custodians of the health of the community.

4. An excellent plan in use in some institutions is the practice of giving talks at the monthly board meeting on some phase of hospital work. A department head might give a brief survey of his work, or several members of the staff might give two or three minute talks. These would give the trustees a better idea of each phase of the work of the institution, and an opportunity to size up their employees as well.

5. In some hospitals today it is found most valuable to have the monthly board meeting and all committee sessions during the luncheon hour or in the evening at dinner. No doubt meetings associated with luncheons and dinners bring out a better esprit de corps.

Hospital superintendents must remember that trustees are usually not men of the medical profession, and they need an opportunity to acquire information about the institution in order that they may more intelligently deliberate on questions arising in their meetings. Hospital superintendents will therefore do well to consider how best they can educate their boards of trustees along such lines.

THE PAY ENVELOPE BECOMES A DUAL INSPIRATION

The pay envelope at Homeopathic Hospital, Buffalo, in addition to the usual encouragement of currency, contains a printed bit of inspiration to staff and employes monthly.

In the monthly envelope is a "stuffer" containing some pertinent suggestions toward economy and efficiency in the hospital, mimeographed on thin white or yellow paper. These inspirational bits are usually quite brief and touch each month on a new subject: tact, courtesy, quiet, small economies, etc.

One or two of them read as follows:

STOP READ THINK

"HOW NOISY THIS HOSPITAL IS!" This complaint is received more often than you realize. Are you making more noise than is necessary? Banging doors, slamming dishes and utensils, loud talking, laughing and walking? Do *your* part to stop these complaints. *REMEMBER*, this should be a house of *quiet*.

BY THE WAY, are you turning out the lights in your room as you leave it, or the one you saw burning that wasn't needed?

MAKE NEXT MONTH'S SLOGAN "COURTESY"

Genuine courtesy springs from the heart, not from the lips:—

"A little more kindness, and a little less creed,
A little more giving, and a little less greed,
A little more smile, and a little less frown,
A little less kicking the man when he's down,
A little more "WE" and a little less "I"
A little more laugh and a little less cry,
A little more flowers on the pathway of Life
Will prevent many complaints and end much of our strife."

Try it out in your daily routine this coming month. You'll be surprised at the results.

THE UPKEEP OF RATS

Hospitals will find rats very costly guests. The cost of their upkeep mounts steadily as is shown by figures in a recent report of the fire-prevention committee of the Building Managers and Owners Association of New York. The report says:

"A year or so ago some one figured out that it costs us $1.80 per person per year to feed the rats in the United States. Recent figures compiled by a British expert place this cost in the United States at $750,000,000 a year which is a trifle over $7 per person. This is simply for food consumed and destroyed and has nothing whatever to do with the very considerable fire loss they cause."

To render meritorious service and refrain from egotism, to appreciate recognition but scorn applause, to study earnestly and produce conscientiously, to do your work well, as much for the love of the work itself as for your weekly pay, to practice self-denial and grant benevolent consideration to others: these are the principles of progress that push men up the ladder of success.

None need fear that he will not fully share in the progress he promotes for every man's work is a silent and insistent declaration of his true worth.

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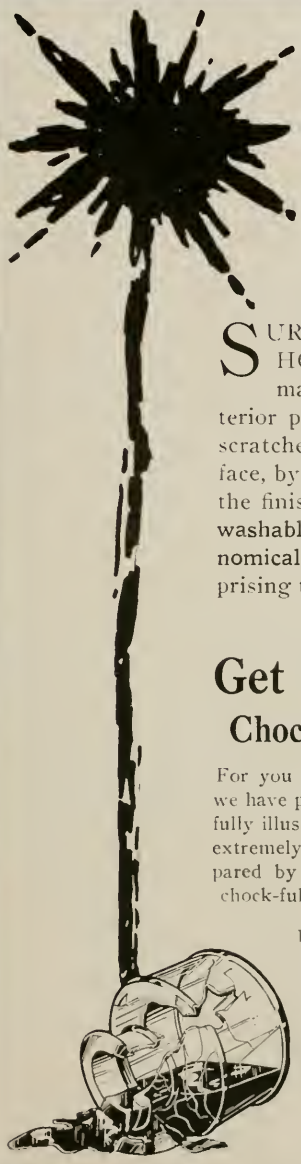

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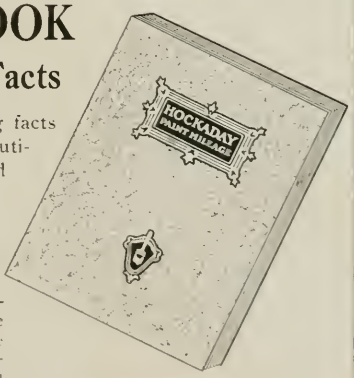
For you who are interested in painting facts we have prepared at great expense a beautifully illustrated book which you will find extremely practical. It has been prepared by a paint expert and it is chock-full of vital information.



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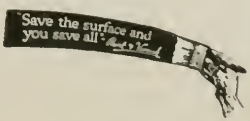

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QUERIES AND ANSWERS

USES OF MOTION PICTURE PROJECTORS

To the Editor of THE MODERN HOSPITAL:

To what uses can motion picture projectors be put in hospitals and allied institutions, such as tuberculosis sanatoriums, homes for the aged, etc.—READER.

Motion picture projectors can be used in hospitals or in allied institutions in the following ways:

To assist in the education of medical students in teaching hospitals.

For purposes of education in schools of nursing.

To some extent for the instruction of interns in non-teaching hospitals.

For the entertainment not only of the hospital's ambulatory patients in some lecture room or auditorium, but also of its bed patients.

For educating the general public as to the facilities and services the hospital has to offer.

To stimulate interest in campaigns for recruiting pupil nurses.

To educate and inform the public in fund-raising campaigns, whether for maintenance or construction.

PRESERVING LINOLEUMS

To the Editor of THE MODERN HOSPITAL:

What is the best method for preserving and keeping inlaid linoleums? Although we have a standard grade linoleum on our floors it has not worn particularly well nor does it have a bright and glossy appearance.

HOSPITAL SUPERINTENDENT.

For inlaid linoleums the best preservative treatment is waxing. Before applying the wax, the linoleum should be thoroughly cleaned by scrubbing with warm suds made with mild soap, preferably a vegetable oil soap. After the floor is dry, a good floor wax—liquid is best—should be applied and rubbed in thoroughly. The use of a weighted brush or an electric floor waxer will give a brilliant polish and a smooth surface to which dirt will not adhere. After three or four such waxings, a week or so apart, the wax need not be renewed oftener than once every two or three months. Daily cleaning need consist only of going over the floors with a dry mop.

Varnishing is the best treatment for printed linoleums. The best results are obtained through the use of a waterproof, thoroughly elastic preparation; ordinary cheap varnishes are liable to crack and turn white or yellow after they have been walked upon for some time.

Extreme care should be taken against the use of soap or soap powders containing alkalis, for their repeated use will make your linoleum wear out in a few years. Perhaps that will explain your difficulty. These alkalis eat into the oxidized linseed oil in the linoleum just as they do into the paint or varnish or woodwork, the base of which also is linseed oil.

EXTERMINATING THE COCKROACH

To the Editor of THE MODERN HOSPITAL:

What is the quickest means of exterminating cockroaches? In spite of extreme care, our hospital, which is an old building remodeled, has become infested with these pests. We have tried various prepared sprays and powders and while they have helped they have not freed us entirely from the roaches. SUPERINTENDENT SMALL HOSPITAL.

Several years ago the United States Bureau of Entomology conducted some scientific tests on insecticides, vermicides and other exterminators and some of these studies concerned the extermination of the common roach. As a result of these tests it was found that sodium fluorid was the most rapid killer of roaches of all the many substances tested. Even when diluted down to 18 per cent content, the chemical was almost 100 per cent disastrous. A mixture containing 50 per cent of sodium fluorid ought easily to kill all the roaches about your kitchen and elsewhere in the institutions.

Barium carbonate and mercuric chlorid give effective results. Arsenious oxid and mercury bichlorid should not be used as both are too poisonous to human beings.

SOILED LINEN IN CONTAGIOUS HOSPITALS

To the Editor of THE MODERN HOSPITAL:

What is the approved method for handling soiled linen in contagious disease hospitals? SUPERINTENDENT.

Many hospitals sterilize their linen before washing, or use sterilizing washers. In the latter instance, a separate sorting room is provided where the linen can be placed in the double-headed sterilizing washer, the other end opening into the clean washing room, or a non-sterilizing washer, one with openings on two sides facing into the infected sorting room and one on the clean side. This is perhaps a good plan in very large hospitals, but it is not necessary in smaller institutions. The important item in the laundering of infected linen is the way it is handled during collection and washing. Methods used in a commercial laundry are not satisfactory or safe, but if the washing is done with water at a temperature of 95 degrees or thereabouts, all organisms, except perhaps some spore-bearers, are killed.

WHAT CASES TO ISOLATE

To the Editor of THE MODERN HOSPITAL:

What cases, other than the so-called infectious diseases, should be isolated in general hospitals?

SUPERINTENDENT OF GENERAL HOSPITAL.

Cases of typhoid fever, pulmonary tuberculosis, anterior poliomyelitis, epidemic cerebro-spinal meningitis, contagious skin diseases as impetigo, etc., erysipelas, lethargica encephalitis, septicemia, tonsillitis, venereal diseases, ophthalmia, trachoma, suspects of all kinds, mental cases, drug addicts, alcoholics and cases which are obnoxious owing to odor, appearance, etc.

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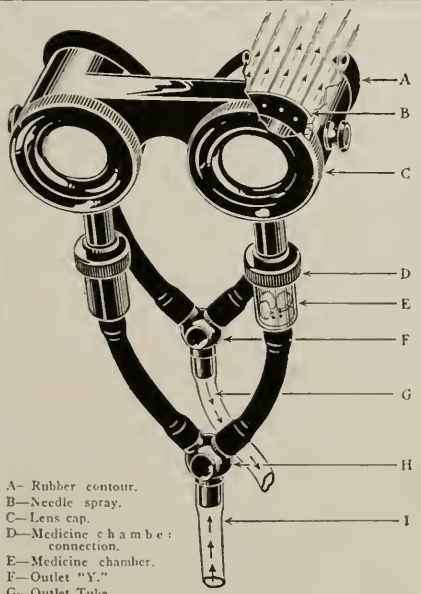

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Book Reviews and Current Hospital Literature

PERSONAL HYGIENE APPLIED

By Jesse F. Williams, M.D., Associate Professor of Physical Education, Teachers College, Columbia University, New York[1].

"The Art of Fine Living" would be an appropriate subtitle to the volume, "Personal Hygiene Applied," by Dr. Jesse Fiering Williams of Teachers College, Columbia. In presenting his book to students and the public, Dr. Williams—who, by the way, is a professor of physical education—has as his aim the improvement of "the quality of human life" and he does not lose sight of his lofty goal on a single page of his 12mo. work.

Nowadays we possess a lively interest in health matters, Dr. Williams asserts, but oftentimes we make health too important as an end, and thus mar life. It is tremendously important, in his opinion, that we recognize health only in its relation to other values.

This from the standpoint of the hygienist is a new angle. "Health for health's sake" has been the slogan of the majority; now our attention is called to "health for life's sake"—mental, social and moral life as well as mere physical well-being. Indeed, cites Dr. Williams, three of the finest things in life—heroism, creative work and child-bearing—are often injurious to health, but to avoid them is to warp life and to misplace values woefully. The sacrifice of health in personal, selfish and unsocial ways can never receive sanction, he says.

The first five chapters of the book are treated in a vein, more or less philosophic, and we get from them something of the author's enlarged viewpoint of health goals. The rest of the book considers hygiene from its scientific side.

Dr. Williams is both scientific and tolerant in his views, and his leadership is away from superstition, fads and tradition into the realms of science and intelligence.

Physicians, nurses and hospital social workers are frequently called upon to furnish some sound guide to patients, parents and teachers in the way of healthful living. This book will answer that purpose in a broader way than many works of pure hygiene.—M. W.

CLINICAL LABORATORY TECHNIC FOR NURSES

By Anna L. Gibson, R.N., Matron Superintendent, Collis P. Huntington Memorial Hospital, Harvard Medical School, Boston, Mass. Revised Edition.[2]

This book owes its existence to the frequent requests on the part of graduate nurses for a simple comprehensive textbook that will enable them to grasp the principles of clinical laboratory technic.

The purpose is to help nurses have a more intelligent understanding of laboratory work and its relation to nursing, and to fit them for positions as laboratory technicians. The arrangement of the chapters has worked itself out from a series of lessons, hence it is the result of experience and has given most satisfactory results.

The chapter headings are Laboratory Equipment, The Microscope, Urine, Feces, Gastric Contents, Sputum, The Blood, Bacteria, Culture Media, Body Fluids, Milk, Preparation of Tissue.

The volume includes all the information required by a student who aims to become a laboratory technician and is free from the mass of detail that makes many books cumbersome.

Descriptions and definitions are simply and clearly stated, which is a great help to the average student, as "laboratory directions" often bewilder rather than direct. A good grade of paper, clear type and useful illustrations are noticeable features.—C.E.G.

THE AMERICAN POCKET MEDICAL DICTIONARY

Edited by W. A. Newman Dorland, M.D., editor "American Illustrated Medical Dictionary." Twelfth Edition Revised[3].

Saunders' pocket lexicon of medical terms has recently had its twelfth revision, and with the addition of several hundred new terms it is strictly up-to-date. The rapidly increasing vocabulary of medicine and the allied sciences necessitates frequent reference to such a work, and this handy sized volume of limp leather invites the busy practitioner or the student to its constant use. Of course, in an abridged work of the sort, definitions must of necessity be brief, but the editor has succeeded admirably in his purpose to make them concise and to the point. In addition to the ordinary terms of medicine have been included numerous tables of doses and other tabulated material.—M. W.

BOOKS RECEIVED

APPLIED CHEMISTRY. By Fredus N. Peters, Ph.D., Former Instructor in Chemistry, Central High School, Kansas City, Mo.; More Recently Vice-Principal. C. V. Mosby Company, St. Louis, 1922.

SYMPTOMS OF VISCERAL DISEASE. A study of the Vegetative Nervous System in its Relationship to Clinical Medicine. By Francis Marion Pottenger, A. M., M.D., LL.D., F.A.C.P., Medical Director, Pottenger Sanatorium for Diseases of the Lungs and Throat, Monrovia, Cal. Second Edition. With eighty-six text illustrations and ten color plates. C. V. Mosby Company, St. Louis, 1922.

1. W. B. Saunders Company, Philadelphia and London, 1922.
2. Whitcomb & Barrows, Boston.
3. W. B. Saunders Company, Philadelphia and London, 1922.

Adv. page 68

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XIX *November 1922* No. 5

AN ECONOMICALLY BUILT SMALL HOSPITAL

By G. R. EGELAND, M.D., Sturgeon Bay, Wis.

THE Egeland Hospital was built to serve a community of 5,000 people. It draws, however, from a radius of some forty miles from a county of over 20,000, with an additional summer population of some 5,000. With the exception of a small frame hospital of fifteen beds and very limited equipment, it offers the only hospital facilities for this large population.

Small communities, up to seven and eight thousand inhabitants, at a distance from large cities are very often handicapped by lack of hospital facilities and the result is that many emergency cases are lost for lack of proper care. Medical men in such communities are likely to get into a line of contentment with themselves and make no effort toward advancement, and thereby the trusting public suffers.

In every locality there should be a hospital for the care of suffering humanity, and every man or woman graduate in medicine should have access to a hospital properly equipped and should use it. Where that is done the highest possible service is rendered to the sick, because each one will try to excel, and the human family is the gainer.

The writer practiced ten years in the country, thirty miles from a hospital which was one simply in name and which lacked equipment. Many hardships had to be endured to get the sufferers to a place of help and lives were lost for lack of proper facilities.

Seven years ago I bought a large frame building and converted it into a hospital. I equipped it as well as it could be equipped and then dreamed and studied the problem of building a hospital of twenty-five bed capacity.

On February 12, 1920, the old building was destroyed and the building of a hospital became a real question. The first plan was a community hospital of seventy-five beds, but in a city of 5,000, factions and cliques are bound to exist and after six or seven months of wrangling and work, the hospital committee had only $7,500 in pledges on a $100,000 proposition. It was obvious that if I wanted a hospital I had to build one myself; which I did.

Everybody knows that as an investment hospitals are the least likely to pay; the fact is that no hospital should be a commercial enterprise.

The Egeland Hospital in its winter setting. How summer enhances its attractiveness may be seen by the view on the cover page.

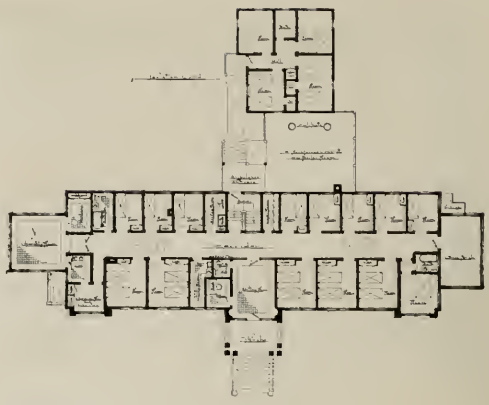
When the great brotherhood of man becomes a real fact, hospitals will be maintained by the state for the care of suffering humanity and the dollars and cents will be stricken from the records, but until that day the money for maintenance must come from some source and as a result the sick and needy pay the upkeep.

The man who has fire loss does not maintain the fire department, nor does the man who is robbed pay for the police and detective force, but those who are sick and in need must maintain the hospitals. Let us hope that at some future time the well folks will maintain our institutions and the sick get just the best the land affords at the least cost to them when in need.

The Egeland Hospital is located on a commanding site, away from the noise of business and traffic, with sunny exposure. The style of architecture is shown in one of the accompanying half tone photographs which was taken at the time of the completion of the building and before the grounds had been finished. The main building is 106 feet long, 18 feet on the east end for the operating room and with a 16 foot sun porch on the west end. It is a frame construction, the exterior of rough cast white medusa cement, the cornice, columns and rail of portico are of wood, painted white. The basement contains the living quarters of the owner, with private entrance, nurses' living quarters with bath, laundry, roentgen ray dark room and vegetable cellar. The kitchen on this floor has a dumb waiter leading to the floor above and a large ice box, as shown on the plan. The first floor has rooms for patients, serving kitchen, sink, toilets, bath, linen room and office.

All stairways are broad and are easily ascended. The interior finish is simple in character, with due regard to hygienic construction and ease of maintenance.

Basement plan of Egeland Hospital



First floor plan of Egeland Hospital

Flooring Materials in Use

The floors in operating room, sterilizing room, utility room, waiting room, office, baths and toilets are of tile as indicated on the plans. The operating room, sterilizing room and bath rooms have a five foot wainscoting of white glazed tile.

The other floors in this story, not mentioned above, are covered with battleship linoleum. All the doors are inlaid birch no-panel hospital type, three feet four inches wide for patients' rooms, to permit beds occupied by patients to be taken out. The entire woodwork on this floor is finished in white enamel, except doors which are stained mahogany, wax finish. The casings are three inches in width and ¾-inch thick; round edges reduce dust collection, and being so narrow the casings can be cleaned with one movement of the arm. The corridor on this floor is seven feet four inches wide and is well lighted by two large skylights, as indicated. The width of corridor permits the easy turning of beds with patients when necessary.

The heating plant for this building is placed in a fireproof enclosure entirely shut off from the hospital proper; the roof is of reinforced concrete six inches thick.

The hospital is heated by an accelerated hot water heating system. The high pressure steam sterilizing equipment is supplied by a small high pressure steam boiler located in the room occupied by the heating plant. The entire building is completely equipped with modern plumbing fixtures, including fire hydrants as shown on the plans. The hospital has city sewer and water con-

A private room at Egeland Hospital.

nections and its private water system for use of hospital is absolutely pure by test.

The operating room is placed out from the building, thereby getting the north, east and south light without skylights, which at their best are troublesome, because of leakage. The sterilizing room and wash room, laboratory and surgeon's rooms are together at the east end of the building and protected from the main hall by a double set of doors, which keep out noise and odors from the balance of the building. The laboratory, drug room, and surgeon's dressing room combine very well and take but small space. If separated they require a great deal of space, which is a loss.

The utility room, linen room and serving kitchen were centralized to reduce labor for the nurses. The front and rear entrances are centralized and are opposite each other giving good air drainage, and the halls are wide making it easy to get patients both in and out. The rear entrance is also an ambulance entrance.

Experience has taught me that large wards in small hospitals are not popular. Anything above two beds is very likely to bring trouble. The element of jealousy easily enters the minds of the sick; they can very quickly find that one patient receives more care and service than another and difficulty results. Two people can very easily be congenial but not six, therefore, I had five two-bed wards, which in an emergency can be made to hold three and still have the cubic feet of air necessary, and nine single rooms, which in emergency can hold two, and after a year's run I find that arrangement to be highly satisfactory.

A contented little patient

The sun porch at the west end of the building was to balance, from an architectural standpoint, the operating room on the east end, but it is much more than a balance. During the warm weather it is used as a recovery room from anesthetics, convalescing patients are wheeled out there daily for air, either in wheel chairs or in their own beds, and during congested times it can be closed up and used as a large ward.

The main hall looking east into the operating room.

The isolation ward was a part of the old building, which remained after the fire. It is a great convenience, being away from the hospital proper, but close enough to be operated in all ways from the main building. Such a ward should be built near all hospitals for use in emergencies which are bound to arise in hospital work.

From my past experience I find maintenance means much and the more hospital you can get on one floor, the less is the cost per head of upkeep. Housing your help in the same building means that you always have them with you and they become more like a large family engaged with you in the care of the sick.

Living in the hospital yourself reduces your personal expenses and has the advantage of keeping you always with your patients. It has had sides, such as never getting you away from work, but taking everything together the man who goes in for a privately owned hospital had better live with his work than away from it. Patients are a law unto themselves and have to be known. Being with them all the time a man learns and knows every detail and can give the patients much real comfort by relieving pain, for no order left on a history sheet, to be carried out by a nurse, can be entirely adequate and this personal care may be very important to the sufferer.

Keeping down the cost of the building has made it possible for us to have thoroughly first rate equipment. We have a first-class operating table, a battery of four high pressure steam sterilizers, plus electric sterilizers for instruments, and water which is used when the high pressure one for any reason is not in use. This obviates the necessity of continually keeping a great head of steam.

Protecting the patients from external sources of danger, such as fire, is of primary importance and while fireproof construction is ideal the cost is such that it is prohibitive for private enterprise or a small community. By attention to details an institution such as I am now presenting can be built in which danger from fire is minimized and where I believe the patients are perfectly safe. The construction throughout might be called semi-fireproof. The outside of the building being rough coated with stucco, with a fireproof roof, has very little exposed wood. The heating plant, high pressure boiler for sterilizer and coal supply are placed in the basement, which is absolutely fireproof, and the only fire within is the cooking stove, which is protected in every possible way. All electric wires are laid in steel conduits. There is not an exposed wire within the building. The partitions and the lower floors are concrete filled, making for strength and stopping fire. A plaster board is used throughout, which is fireproof. The lower floors are laid upon sleepers laid in concrete which have an inch and one-half of air space. There is, therefore, no possibility of rats or mice getting into the building and beneath the floors.

The operating room through the windows of which may be seen a lovely garden of flowers and shrubbery.

Each door will allow the passage of the bed, with the patient upon it, into the hall and out of the building, and all beds are mounted on six inch casters so that they can be rolled anywhere with ease by one nurse. I estimate that without extra help the building could be emptied without discomfort to the patients in less than one-half hour.

The roentgen ray room was placed in the living quarters, because there was space there for such a room (in which no light could be brought) owing to the position of the boiler room, and also to give more real hospital space on the upper floor; the arrangement, however, is not satisfactory. This room should be next to the operating department, particularly for fracture work. The lack of an elevator in this building makes the position of this room very inconvenient in fracture work, patients having to be carried to and fro up a flight of stairs.

The laundry room was converted into a drying room and the laundry placed away from the building. The odor and steam from a laundry in the building make it objectionable, but a drying room is not offensive.

The hospital, while strictly privately owned, is run for the general public and any man can operate his cases here if he is capable and so chooses.

The upkeep and expense of maintenance must come from receipts from patients or the owner must make good any deficit; there are no contributions or endowments. So far the hospital has been selfsupporting, but should it not pay, the increased ability to do work, the better class of work that can be done, and the general satisfaction of being better able to help suffering humanity would compensate for any cost it may be to the owner.

The fireproof roof, enclosed wiring, separate heating plant, and other items I have mentioned would make the building a slow burning one. With the consideration which I have given to these details and to the problem of getting patients out in times of emergency without extra help, I feel that while we are not strictly fireproof we are very safe from fire for the patients, and the cost of construction has been held down to a point where any community can have an adequately equipped hospital.

The plea I want to make in presenting the account of this hospital is first: Keep the building code of the various states so that hospitals can be built safe for the patients, but not at a prohibitive cost, and second, build small hospitals in all communities thereby saving human life and making doctors more efficient and better men.

The greatest truths are the simplest; and so are the greatest men.—Hare.

SOME FACTS ABOUT FIRE INSURANCE AND LOSS ADJUSTMENTS

By PHILIP G. CLIFTON, Chicago.

LET it be understood at the start that there is no deep mystery about fire insurance. Neither is the insurance policy contract a document bristling with provisos, prohibitions and stipulations to trap the unwary business man. And strange as it may seem, adjustments are not made on the principle of paying as little as possibly can be paid.

It is true that fire insurance as it stands today is the result of development. And like all businesses there has undoubtedly been in this certain mistakes and abuses. These past mistakes have been magnified and their history has been so frequently reiterated that many believe there is a question as to the validity of any insurance policy.

Big men at the head of large concerns seriously believe that insurance companies can easily find loopholes so that they need not adhere to the contract in settling losses. But this opinion is the result of not knowing the requirements of the contract.

Ignorance of any proposition breeds suspicion or carelessness. Policies are rarely read and imperfectly understood when read. Any general contract offered to the public at large must have certain restrictions and must contain requirements on the part of the insurer and the insured in order mutually to protect both their interests. It is a fallacy that their interests are different—they are identical.

With but few exceptions fire insurance companies use a state standard form policy made mandatory by the state in which they operate. The New York standard form of policy is the one that is generally used as it embraces nearly all that is contained in other forms. One familiar with its requirements can readily understand the amendments that any state makes.

Earlier insurance contracts had their faults. Each company endeavored to make its contract as attractive as possible. Rates were not uniform. The operation of swindlers, together with the confusion in adjustments caused by different contracts on the same loss, created an intolerable condition. This was remedied by state supervision and a standard form of contract.

The New York standard form is the best example. The fact that it has stood the test for years is evidence that it is equitable to the policy holder and to the insurance company.

NO MYSTERY ABOUT INSURANCE

"An insurance policy contract is not a document bristling with provisos, prohibitions and stipulations to trap the unwary business man," says the author of the accompanying article who is connected with an appraisal company of high standing. "Ignorance of any proposition breeds suspicion or carelessness. Policies are rarely read and imperfectly understood when read. Any general contract offered to the public at large must have certain restrictions and certain requirements on the part of the insurer and the insured in order mutually to protect both their interests. It is a fallacy that their interests are different—they are identical."

The rider form directly applies the insurance to fit the facts and conditions of the particular risk. It also amends the standard form, which is not a contract until completed by descriptions and amendments. The rider form should give the correct name of the assured and should correctly describe the property insured.

The drafting of rider forms is standardized to a large extent. Concerns in some lines of industry require broader permits than others. It is no advantage to have any broader permits than the business requires.

No one is better qualified than the informed agent or broker to draft a form that fully protects the owner against loss. The agent is thoroughly familiar with the risk offered and he is in position to know what permits fit the condition. While he is the "agent for the company" his business success depends upon how well he serves the owner. Many agents and brokers have their own inspectors, who give the owner much service in addition to that of inspection bureaus.

The agent knows that to secure a permanent client he must suggest changes to lower the rates. The best and largest agencies have been built up on that kind of service, the popular belief to the contrary notwithstanding.

Coinsurance

Probably the greatest factor in the reduction of fire insurance rates has been the use of the coinsurance clause. Instead of being a hardship on the owner, it has been a blessing. Were not co-

insurance in force on the major portions of sizable risks in the country the rates would be much more. There has been mistaken legislation in some states prohibiting its use. Were it not for coinsurance the blanket form of insurance could not be used.

Coinsurance is a form of insurance in which the person who insures his property for less than its entire value is understood to be his own insurer for the difference which exists between the actual cash value of the property and the amount of the insurance. When the loss is not greater than the insurance the amount paid is in the ratio of the total amount of insurance to the full value of the property.

A great many business men object to the coinsurance clause because they think that it means that the insurance company will pay only a certain proportion of any given loss. This is, of course, a mistaken idea. The clause has no effect whatever on the adjustment of losses, *if the clause is lived up to by the assured.* It is only when the assured does not maintain the agreed amount of insurance in proportion to value that the clause is operative.

All business men should, if they have not already done so, ascertain accurately the present value of the property they wish to have insured, and then take steps to have their insurance amount to the agreed percentage (usually 80 per cent) of such value. If this is done, the insured will be entitled to collect any losses he may have, just as if the clause were not attached to the policy.

The most usual coinsurance clause is based on the assured agreeing to carry 80 per cent of the value of his property, and the following example, worked out on the basis of varying increases in value, will, I think, illustrate clearly the operation of the clause:

EXAMPLE OF 80 PER CENT COINSURANCE CLAUSE

Three years ago:		
Value of building and contents	$50,000	
Insurance carried	40,000	
Loss by fire	10,000	
Paid by insurance company		$10,000
Now:		
Value of building and contents	$75,000	
Assured should carry 80 per cent of value or	60,000	
*Insurance carried	45,000	
Loss by fire	10,000	
Paid by insurance company—75 per cent of loss, or		$7,500
Assured must bear 25 per cent of the loss, or		2,500

*Insurance carried is only 75 per cent of what assured should carry to comply with the requirements of the 80 per cent clause.

Adjusting the Fire Loss

The humorist Bill Nye once defined an insurance adjuster as "one who stands between the insured and immediate wealth." In the next sentence he states "if it were not for the adjuster the insurance company would soon give away all its wealth and fetch up in the poorhouse."

In the entire ramification of insurance no phase of the business is more difficult or more important than that of adjustment of losses. The business man judges the entire system of insurance by the manner in which his loss is settled.

The insurance companies employ the best talent obtainable to handle their adjustments. These adjusters are skilled in gaining the claimant's confidence and their endeavor is to make a settlement that is fair to the owner and to the companies they represent.

The adjuster for the insurance companies has the advantage to the extent that loss adjustments are his every day business. He has a complete understanding of the contract conditions and knows every procedure in making the settlement.

However, the adjuster frequently believes that the owner has the advantage because the adjustment depends to a large extent upon the integrity of the loss claimant and the records that he produces.

Adjusters view a loss from an impersonal, professional standpoint with full realization that their own money is not involved and their own business is not in jeopardy. On the contrary the loss claimant cannot view the matter impersonally because his money and business are involved. Added to this disadvantage to the owner is the fact that he rarely knows what is expected of him and the principles underlying adjustments.

The situation calls for cool-headed consideration by both the claimant and the adjuster. Patient analysis will disclose that differences are largely imaginary and that cooperation will be beneficial to both.

The business man who waits until a loss occurs to find out what he should have done, may find himself in the position of one who "locks the stable door after the horse has been stolen."

There are two points relating to values that many business men do not realize until they have actually gone through an adjustment: first, that *the adjustment is made on the basis of the cash value at the time of fire* not the value at the time the insurance was taken out; second, that the adjustment is made on the sound or depreciated value, not the value to replace new.

Upon reflection it will be seen that both these points are proper and just.

The insurance policy is a personal contract. Strictly speaking, it does not insure the property; it indemnifies the policyholder for loss accruing to him personally by reason of the damage or destruction of certain property at the time of the fire. At the time the insurance was placed on a stock of flour its actual value, we will assume, was $1,000. Later at the time of the fire, its actual value was $1,200. Were the loss settled on

the basis of the $1,000 valuation the owner would lose $200. On the other hand, were its value $800 when the fire occurred the insurance company would lose $200 if the company settles for $1,000. Settling the loss on the basis of the actual value at the time of the fire prevents loss to either the owner or the company. This is equitable and just.

Were losses settled on the basis of the value to replace new, the property a moral hazard would be created which would put a premium upon dishonesty and carelessness. Insurance companies must provide surpluses through the medium of premiums to meet the losses; therefore, the more losses, the larger premiums.

Line 2 of the New York standard policy reads: "This company shall not be liable beyond the cash value of the property at the time any loss or damage occurs."

The legal definition of actual cash value is "that resultant value obtained by deducting from the replacement value new, the actual depreciation." Any system of valuation that accurately determines the value to replace the property new, the amount of actual accrued depreciation and the resultant sound value, will be accepted by adjusters. Systems have been devised which bring accurate results.

To assist the adjuster in obtaining the essential facts, the policy makes it obligatory for the owner to make, in case of personal property, a complete inventory of the same, stating quantity and cost of each article and the amount of loss claimed thereon. This provision has led many to believe erroneously that the loss was settled on the past cost. The owner has sixty days in which to make this schedule. The company grants more time if necessary.

Valuation and Depreciation

Insurance is paid upon the basis of the cash value of the property at the time and the place the loss occurs.

Book records of past costs of property do not show the cost to replace the property new at the time of the fire, neither do they show the actual depreciation. Since the cost to replace property items are constantly fluctuating and depreciation is not occurring at a uniform rate, the book records no matter how accurately kept, cannot be used for adjustment purposes.

Many old properties have been "charged off" upon the books of account and consequently represent no value. This does not in any way change their actual intrinsic value and, if loss occurs, the owners of these plants are entitled to present claim for cost of replacement less accrued depreciation.

Original cost is seldom the same as today's real value; property value is rarely the same thing as the total of plant investment; and neither the original cost nor the investment is the same thing as today's cost of reproduction less the depreciation.

Books of account, if properly kept, show investment of original cost. Appraisals, if properly made, show the present cost to duplicate the property, the actual accrued depreciation and the resultant sound value.

How the values on the books of account would differ because of a difference in the policy of two managements is shown by the following illustrations:

Ten years ago Management "A" takes a new property whose asset value is $100,000. It decides to "write off" 10 per cent annually for depreciation. The books of account would show the plant account of the original property to be at this time about $39,000. If Management "B" had taken charge of the property and had decided to "write off" 5 per cent annually its plant account would be approximately $63,000.

A correct appraisal would show that the actual value of the property was the same for Management "A" as for Management "B." The books of account show simply as an account procedure, a depreciation which is an arbitrary percentage determined usually by custom or circumstances related more to "balance sheets" than to actual wear and tear.

One must not conclude that the custom of "writing off" an annual, uniform depreciation is wrong as a business policy. It is, however, wrong to consider such depreciations as the "actual depreciation." Actual depreciation must not be confused with theoretical depreciation. The two are different and should be used each for its particular purposes.

Because of the theoretical system of accounting, book depreciations are not actual depreciations, and because the insurance contract pays on the basis of actual depreciation, the service of making appraisals has come into existence. Many business men consider it rather a delicate situation to be the source of two different bases of value. For this reason and for reasons of economy and efficiency, many concerns employ the services of professional appraisers. They realize that with a correct disinterested, authoritative appraisal report all interests depending upon actual values are amply protected.

Gentleness and cheerfulness, these come before all morality; they are the perfect duties. * * * If your morals make you dreary, depend upon it they are wrong. —R. L. Stevenson.

IOWA COLLEGE TOWN HAS ACTIVE COMMUNITY HOSPITAL

By LUTIE B. LARSEN, Superintendent, Grinnell Community Hospital, Grinnell, Iowa.

THE Grinnell Community Hospital is the outgrowth of several factors; chief among these was the need for better care for the sick in the community.

In 1907 several public-spirited citizens bought and equipped an old residence to be used as a hospital, the city voting a tax to pay the deficit in operating expenses. This hospital was soon outgrown and in 1918 an active movement was begun to raise funds for a real community hospital. A site and $75,000 were given by popular stock subscription. Later, by reason of further gifts, the site was changed and a full city block purchased for about $10,000, leaving $90,000 for building and equipment.

A modern fireproof building with accommodations for forty-five patients was constructed and was ready for service August 1, 1919. The main building, of brick, is 38x88 feet, three stories and basement with terrazzo floors throughout. In the basement are the kitchen, dining rooms, store rooms, laundry, classroom, boiler room, rooms for help, and the laboratory. The first floor is partly for adminstration and partly for patients. The second floor is devoted entirely to the care of patients. One half of the third floor is occupied by the operating and x-ray rooms, the other half by the obstetrical department. On the first floor, in the rear, is a large porch; on the second and third floors are large solariums. A signal system is installed throughout the building.

The location and surroundings of the hospital are especially attractive. The hospital stands in the middle of a full city block and everything in the way of landscape gardening has been done to make the place attractive. It is hoped that in the near future it may be possible to build a modern nurses' home on the grounds in the rear.

The ambulance entrance is at the rear. Just inside the rear entrance there is an electric elevator which makes for easy transportation to any floor, of any kind of case, whether wheel chair or stretcher.

Yearly Tickets Entitle Students to Care

In planning this hospital, the necessity for an isolation hospital was not lost sight of. Grinnell, being a college town and having from 900 to 1,000 students, probably needs a contagious department more than most towns of its size. This, a small building of stucco entirely separated from the main one, accommodates twelve patients and has been very useful since its opening. Many students from the college have been cared for and many citizens of the town have found it much more convenient to go to the hospital than to have the home quarantined. The usefulness of the place is more apparent every year and the patronage has shown a steady increase since its opening. The expense and care of contagious disease in the home is so much greater than in an institution that more and more those who are afflicted with

The Grinnell Community Hospital houses 45 patients.

contagious diseases are seeking the care offered by this department.

"Student insurance" was issued in the fall of 1921 by the hospital management. This provides for care in the hospital in case of illness. At the

The grounds are ample and pleasingly landscaped.

beginning of the school year the student may purchase a "hospital ticket" which costs $5 for the year or $3 for a semester. This entitles the student to hospital care for a period not to exceed three weeks. This includes board, room, laundry, medical dressings and nursing care. It does not include special nursing care, x-ray, operating room or laboratory fees. This fee is payable with the tuition at the college office.

This insurance is, I believe, an original idea as I cannot learn of any other hospital giving such insurance. It has proved very satisfactory to both the student and to the hospital, and has found such favor with the faculty of the college that the members have asked to have some kind of insurance arranged for them. This will probably be done.

The laboratory is well equipped for all the routine hospital work, including the various bacteriological procedures and blood chemistry. It has almost since the beginning been an authorized branch of the state board of health laboratory, and in the year 1921, 475 examinations were made for diphtheria. The average total number of examinations per month was 104. Every issue removed at operation was examined grossly and microscopically and recorded. It has been a house rule to do a routine urinalysis and leucocyte count on all operative cases, and the coagulation time taken on all patients entered for tonsillectomy.

During the past year and a half the laboratory has been in charge of a graduate physician who devotes her entire time to pathology, doing work for local physicians when not busy in the hospital.

The x-ray department consists of one large main room and a smaller dark room. It is in charge of a physician-roentgenologist who is also the pediatrician.

A child welfare clinic was established through the generosity of one of Grinnell's leading citizens. Clinics are held twice a month and excellent work is being done. Scores of unnoticed defects have been pointed out, and children from nearby towns and many who are merely visitors have availed themselves of the opportunity for a thorough examination. It is free to anyone who desires to bring children to the clinic.

In cooperation with the Social Service League a free dispensary has been opened. The secretary of the Social Service League after making sure the applicant is really unable to pay for medical

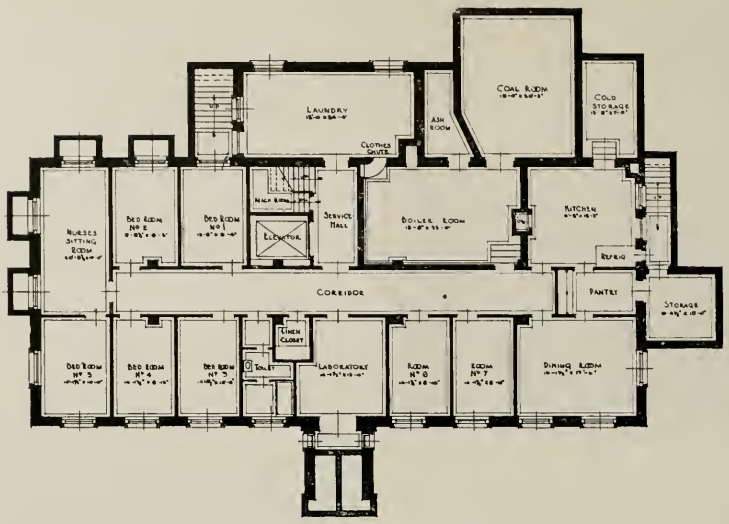
A rear view of the hospital building. The ambulance entrance is here.

aid, issues a ticket which entitles the holder to free examination and treatment. Though the demand in this kind of a community is not large, we have during the past winter given aid to many, for here as elsewhere there has been unemployment.

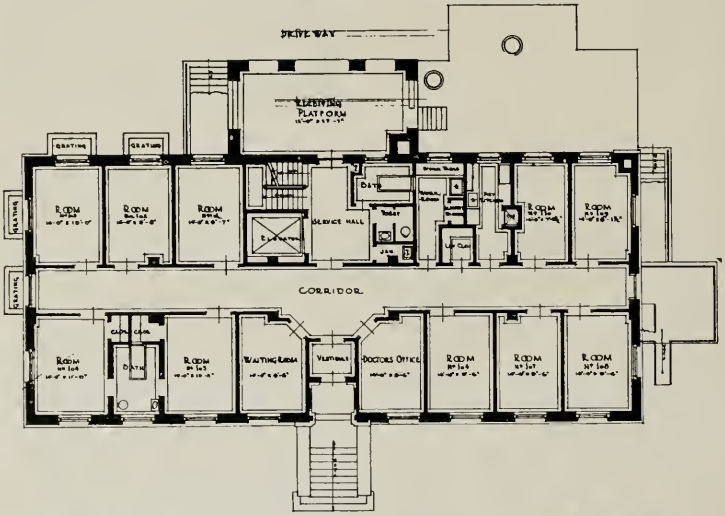
Prenatal Clinic Gives Needed Help

A prenatal clinic was opened the first part of 1922 but so far has not been well patronized. It is a new idea in this locality and its benefits are as yet not understood by the public, but we are undismayed and feel it can be developed. The department is in charge of the superintendent. It does not include medical or obstetrical care, for this the patient is referred back to the family physician. It is simply a round table with the expectant mother to advise her about small things with which she would not think of troubling her physician, to advise in regard to the baby's layette, to emphasize the necessity of personal hygiene, etc.

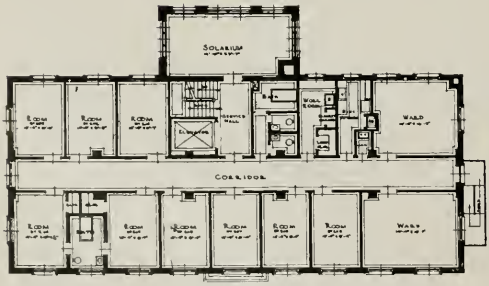
We have our share of charity cases, some of which are paid for by the county; a few are cared for by a generous citizen who has provided $500 per year for this purpose, and this amount is always overdrawn. Some time this year we hope



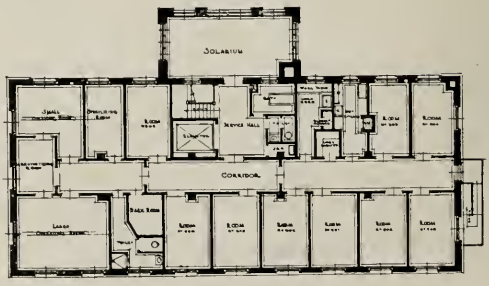
Basement plan of the Grinnell Community Hospital.



First floor plan.



Second floor plan.



Third floor plan.

The laboratory is equipped with some completeness and is an authorized branch of the state board of health laboratory.

to have a financial campaign to help make up our deficit. We recently received a legacy of $25,000 and when that is available it will be made the nucleus for an endowment fund.

In the early part of the first year a training school was established. It is accredited and has affiliation with the State University Hospital at Iowa City. Each nurse during her senior year has six months' service in that hospital. We have just graduated our first class, a class of only two.

The staff of the hospital is composed of most of the regular reputable physicians of the town and one or two from each of the neighboring towns in a twenty mile radius. The staff has a general direction over the professional conduct of the institution, but only licensed practitioners are allowed to practice in the hospital at present. The effort to meet the requirements of standardization has not been a complete success, owing partly to the conflict of the personal equation among the members of the staff. Pressure along this line is continually exerted, however, and it is expected that opposition will eventually be overcome and the requirements established to the satisfaction of all concerned.

Another actively functioning corner of the laboratory.

Once in two months we issue a hospital bulletin. In this way we try to convey to the public our needs and what is being done in the hospital. We publish the names of those who have contributed since the last issue, items of interest in the training school and similar notes. Now we are urging the necessity for a nurses' home.

Looking back upon the last three years we feel that much has been accomplished and this gives us reason to hope that the next few years will find us steadily increasing our usefulness in the community.

AIDS CHINESE HOSPITALS BY MEANS OF MEDICAL SCHOOLS

The experience of the China Medical Board of the Rockefeller Foundation seems to indicate that the most effective way to aid the hospitals in China is to improve and extend the facilities for training of doctors, nurses, and technical workers of various kinds who cannot now be found in adequate numbers in China or abroad, even when funds for their support are available, says the recent annual report of the board.

"In practically all countries it is recognized that even those hospitals which are not connected with medical schools have important educational functions to perform. This is particularly true of the hospitals in China. Besides training interns and nurses they provide opportunities for the continued employment of young doctors who need the facilities of the hospital and the friendly guidance of more experienced men if they are to continue their professional growth. Local medical associations in China have been little developed; there are no medical libraries except in the schools; and outside of a few large cities there is no systematic provision for stimulating professional intercourse between practicing physicians. Association with a good hospital can do much to compensate for these disadvantages, and thus conserve for future usefulness the men turned out by the schools.

"The hospital has also a useful part to play in the education of the public. In many cases the mission hospital is the only place where modern medicine is practiced, and the only center for popular health education."

Since the China Medical Board began its work in 1915, grants have been made to mission hospitals to enable them to improve their work, through additions to plant and equipment or through increases of staff and maintenance appropriations. In 1921 payments were made to sixteen such institutions, amounting to $123,986.

DR. RAPPLEYE TO NEW HAVEN HOSPITAL

Dr. Willard C. Rappleye, secretary of the Committee on the Training of Hospital Executives which recently submitted its outstanding report, has been named head of the New Haven Hospital, the teaching institution of Yale University and professor of hospital administration at Yale medical school. Dr. Rappleye succeeds Dr. Harold W. Hersey, now connected with the Joint Administrative Board of Columbia University and Presbyterian Hospital, New York. Dr. Rappleye was formerly director of hospitals for the University of California.

A PROPER LOCATION FOR THE HOSPITAL PHARMACY

By RICHARD RESLER, Resler & Hesselbach, Architectural and Consulting Engineers, New York.

THE preparation of this paper has been prompted by the writer's investigations and observations of certain existing hospitals and others in course of construction wherein a lack of sound study of the necessary requirements for the proper and efficient location of the pharmacy and drug storage room has manifested itself.

The size of the pharmacy is dependent to a great extent on the character of the institution, and its class of work. Obviously the drug requirements of an orthopedic hospital differ from those of a general hospital. Then the question of drug preparation was of more importance twenty years ago than now, for there are a number of physicians and surgeons at the present time who are depending to a certain extent for the cure of their patients upon dietotherapy.

Whether the pharmacy should be included in the plans for the first or ground floor must be governed by local conditions, such as the topography of the property, approach to the hospital, orientation, location of the hospital entrance and out-patient department. These are positive contributing factors in arriving at a proper and efficient location.

Central Location is Essential

In view of the fact that all medicines, both special prescriptions and proprietary, radiate from the hospital pharmacy it is manifest that this important department should by all means be centrally located to reduce to a minimum the many services therefrom.

In a typical general hospital *without* an out-patient department the pharmacy should be located as nearly equi-distant to the extreme ends of the hospital patient service as is possible and at the same time it should be convenient to the elevator and stairs. In an institution *with* an out-patient department it is important to locate the pharmacy convenient to this department with one window serving it and another the hospital proper.

In a hospital group it is highly desirable to locate the pharmacy in so far as is practicable equi-distant to the ward buildings. In case provision is made for the out-patient department in the administration building it is preferable for the pharmacy to be located in this building.

In planning for pharmacies it must be borne in mind that the pharmacy itself is a room wherein drug preparations are made and dispensed with an amount of drug storage sufficient for current needs only, therefore the drug storage room, which in reality is an integral part of the pharmacy, should be located convenient thereto. If it is not possible to locate the drug storage room adjacent, it should be located directly under the pharmacy with a connecting stairs.

The subject of drug storage is an important one and should be seriously studied with a view to providing adequate facilities for the storage of and access to the various cases and barrels. It frequently happens that opportunity is presented the institution to purchase drugs from the wholesale drug house in bulk at a considerable saving in cost, and in order to permit the hospital to avail itself of such an economical procedure it is necessary to provide storage for this purpose.

Open shelving should be provided in the drug storage room for bottled and cased medicines, with racks properly tilted to draw off the supply from kegs and barrels. In a small institution storage for barreled supplies is not nearly so necessary, as the purchase is usually made in smaller quantities. Space must be allowed for special manufactured supplies made up in large quantities by the wholesaler on prescription and a storage vault for combustibles opening directly off the dry storage room is desirable.

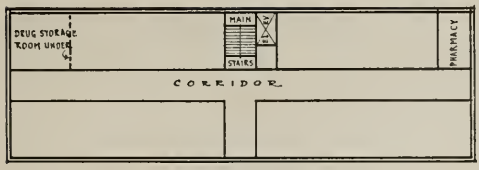
Since the life of certain drugs is seriously impaired by dampness the drug storage room and pharmacy should be perfectly dry and well ventilated.

Frequently the pharmacy is located in what originally was vacant space with the result that the room is not only poorly ventilated but is deficient in natural daylight. The pharmacy should receive as careful consideration from the standpoint of daylight as an operating room. Large windows which extend up to the ceiling with a north light are preferable.

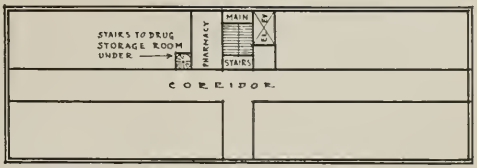
Wood Floors and Tables Preferable

The pharmacy proper whether in a general hospital or one with an out-patient department should be planned carefully to minimize the steps of the druggist or his assistants. From the writers' investigations and inquiries among hospital pharmacists, it is found that a wood finished floor is preferable not only from the standpoint of resilience but as a saving in glass breakage.

Breakage of glassware, such as bottles, stoppers, graduates, funnels, mixers, etc., amounts to



(A) A layout to be avoided.



(B) A conveniently located pharmacy.

a great sum by the end of the year. It seems desirable to construct all counters and work tables of wood in order to minimize this breakage.

The pharmacy should be provided with cabinets along the wall to a height of approximately 37 inches from the floor for the storage of small cases and canned drugs. They can be finished with counters at the top.

A number of small drawers should be provided for proprietary medicines made up in the shape of pills and capsules. The upper part of the cabinet should have open shelving approximately 10 inches on center with the shelves about 6 inches wide, adjustable but firmly fastened, to obviate the danger of upsetting the entire shelf in case one of the bottles sticks, a situation which frequently results in considerable damage.

A section of the shelving should be enclosed with glazed doors equipped with a separate locking device so that poisons and narcotics can be stored.

It is desirable to provide space for a pharmacist's desk, filing cabinet and storage of stationery, such as prescription pads and labels. Racks with notches in them are convenient for hanging glass funnels and graduates. Storage for empty glass bottles should be provided.

Some Necessary Equipment

Alberene stone appears the most desirable material for drug sink and drain boards. Hot and cold water should be provided with gooseneck faucets set a height above the sink sufficient to permit the filling of bottles at least of five gallon capacity. Should the hospital not be equipped with a central water still, a small one should be installed in the pharmacy in a convenient location on the wall.

Electric and gas outlets should be furnished and a small refrigerator for the storage of serums and vaccines should be provided. Sliding metal drawers in the refrigerator are a great convenience.

In the writer's opinion it is necessary to equip all cabinets and closets in the pharmacy with glazed doors, not only to facilitate checking of the drug supply on hand, but to facilitate access to the required medicines. Horizontal sliding doors, because they do not project into the room when opened, have been found most satisfactory.

Should the institution be a large one where prescriptions are left for filling in the morning, it is necessary to equip one part of the pharmacy with a number of bins corresponding to the wards in the hospital wherein a prescription to that particular ward can be filed pending distribution to the ward.

If it is the intention of the hospital to provide the nurses with pharmaceutical training it is necessary to arrange sufficient floor space for this purpose.

In a small institution the interns as a rule prepare the prescriptions but in a medium-sized one it is desirable in order to maintain proper control in this department and not to have nurses and messengers passing in and out of the room to equip the door with a sliding section, the upper half of which will act as a counter and information window. In a large hospital the interior counters are arranged in such a manner as to form a vestibule, thus preventing intrusion.

DON'T SUBSCRIBE THROUGH FIELD AGENT

The Modern Hospital Publishing Co., Inc. has no subscription agents in the field for its publications. Renewals and new subscriptions are handled entirely through its central offices.

This statement is made after new complaints from hospital superintendents that no copies of the magazine have been received since they paid some person, representing himself as an agent of THE MODERN HOSPITAL, the price of one or more yearly subscriptions.

Latest reports on such fraudulent practices comes from the state of Georgia, where a man, giving his name as Hugh Gordon, has taken checks from several hospital superintendents and nursing supervisors. They have cancelled checks for the subscription price.

PUBLIC HEALTH BILLS BEFORE CONGRESS

Only 1½ per cent of the bills and resolutions introduced in the 67th Congress were concerned with national health. During the two sessions of this Congress, the first session of which convened in April, 1921, and the second session of which adjourned on September 22, 1922, over 18,000 bills and resolutions were introduced in both houses. Of this number, less than 300 pertained to public health. Five hundred and eighty-seven bills and resolutions became laws but only about 25 of these were measures of direct interest to sanitarians.

This information comes from the National Health Council which has issued thirty-six biweekly *Statements* on National Health Legislation.

A YEAR 'ROUND HOME FOR CONVALESCENT CARE AND RECREATION

By VALERIA LANGELOTH CLARK, President, Board of Trustees, Valeria Home, Inc., Cortlandt, N. Y.

THE Valeria Home for recreation and convalescence, the origin and tentative plan of which was announced in THE MODERN HOSPITAL for February, 1921, as "a new idea in health conservation," is now in course of construction and a real beginning has been made in what is believed to be a new departure in institutional service. At the time the former article was written for THE MODERN HOSPITAL the plans for carrying out the wishes of the founder, the late Mr. Jacob Langeloth, were not fully matured, but now that actual construction has begun some further description of its architectural plan and service program is necessary in order that those interested may have a clear understanding of a social service which, in many of its features, is unique.

The Valeria Home is intended to provide year-round convalescent care and recreation for men and women of education and refinement who do not want or need charity, but who are unable because of small incomes to avail themselves of private sanitariums and health resorts conducted on a commercial basis. As directed by the founder the Home will be as far as possible self-supporting, but its rates will be kept low enough to enable any eligible man or woman to enjoy its service. All guests will be paying guests, but what they shall pay will depend upon their ability to pay. Eligibility for admission to the Home will not be restricted to the members of any racial, religious or social body or group, except that for reasons of policy, negroes will not be accepted.

No Fixed Rule of Eligibility

The eligibility of the applicant for admission will be determined in each case after investigation of his character, ability to pay and other circumstances. No person will be accepted who is suffering from any communicable disease or any other disease or condition requiring the routine attendance of a physician or a nurse, or who, in the opinion of the admitting committee, is not likely to prove a desirable or congenial guest. Length of stay of guests will be limited but will depend upon the circumstances in each case. The Home is not intended as a permanent residence for any guest and the board of trustees has no intention of permitting it to become a home for

This airplane view of a portion of the Hudson valley shows in the foreground the site of Valeria Home, Westchester County, New York

The general plan of Valeria Home.

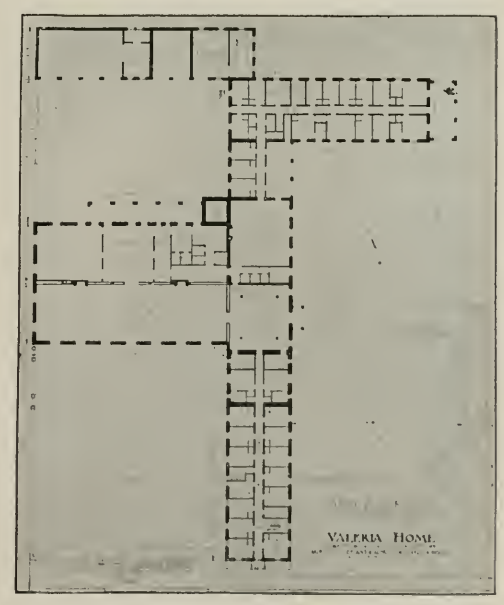
chronic invalids or for the aged. The will of the founder clearly implies that promotion of the health and welfare of self-supporting, working men and women is aimed at, and while there will be no fixed rule of eligibility as to age, effort will be made to provide chiefly for persons of working age. No person under sixteen will be accepted, but the upper age limit will be determined according to need. Opportunity to enjoy the Home will not be restricted to residents of New York or its environs; any person, wherever he lives, if eligible, will be accepted.

The site of the buildings now under construction was selected after careful survey of available lands in the neighborhood of New York, since it is expected that the majority of guests will be residents of that city and its vicinity. The tract of land finally purchased comprises about 1,000 acres of varied farm and woodland in the highest part of the Westchester Hills about an hour's ride from New York. The area includes two mountains, or rather hills, which are densely wooded and from the summits of which a wide stretch of the Hudson River valley can be seen. A small lake about three-quarters of a mile long and half a mile wide adds greatly to the attractiveness and usefulness of the property. Old farm lands which were run out and many acres of swamp lands have been reclaimed by thorough drainage and cultivation. The greater part of the acreage is virgin forest but there is sufficient cleared meadow land and hillside to make possible the development of all kinds of outdoor recreation both summer and winter.

Capitalize Natural Features

Having acquired this great area so well suited to the founder's plan, selection of a location for buildings so as to take greatest advantage of the natural features of the property was the next step. After study of all possible locations, under varying weather conditions, the south slope of Keg Mountain, shown at the extreme left in the airplane photograph, was chosen. The buildings will, therefore, have a southerly exposure and will be protected against the north winds by the hill at their back. The lake, which has Keg Mountain at the north and Salt Hill at the east, will be immediately in front of the buildings and somewhat below them, so that guests will have a most attractive view of the water and the hills which hedge it in. The surrounding forest of oak, beech, maple and elm has been preserved and no more landscaping will be done than is necessary to give the buildings the best outlook and proper exposure to sunlight and the prevailing southwest breezes of summer. This situation of buildings seems to be ideal for year round service.

The buildings are being built entirely of native stone quarried on the site. Such selection of stone is being made as will harmonize well with the natural surroundings. Special care is being taken by the architects to avoid the coldness and rigidity which so often characterize institutional masonry, by keeping buildings low, by the use of stone of irregular shape and varied color, aged and worn in its natural setting, and by pointing up walls in such a way as to smooth and soften the joints in the masonry. The general effect aimed at is that seen in many of the early Dutch colonial homes throughout Pennsylvania, where permanence of construction, in spite of the simplicity, sometimes severity of architectural lines, gives an appearance of warmth and homelikeness not found in more modern stone buildings.



Main floor plan of The Hall group of buildings.

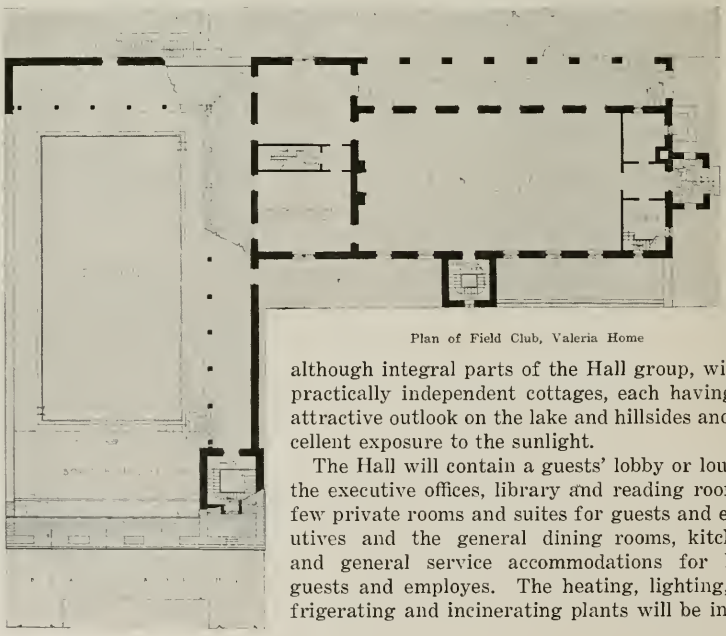
All buildings will be as nearly fireproof as it is possible to make them by means of stone, steel and reinforced concrete construction. Cement, tile and terrazzo floors will be laid wherever such non-absorptive material is desirable, as in kitchens, store rooms, laundry, garage, corridors, etc. Floors of offices, guest rooms and entertainment rooms, will be chiefly of quartered oak. All interior stairs, with the exception of the main staircase of the central hall, will be of reinforced concrete with slate treads. Partitions will be of hollow tile, and metal lath will be used throughout. The roofs of all buildings will be of slate of varied colors and irregular lengths and widths, so as to harmonize well with the natural wood tones of the hillside.

Will Feature Rest and Recreation

The complete plan as designed by the architects and shown in the accompanying sketch, calls for three major groups of buildings, arranged in the form of a crescent, namely, a central administration and residence group called the Hall group; six guest cottages, known as the Cottages, adjacent to it on the east; and the Field Club or recreation center at the southwest and about an eighth of a mile from the central hall. The grouping and arrangement of these buildings are designed to serve as independently as may be the three major service functions of the Home, namely, food, service, rest and recreation. All food for guests and employes is to be prepared and served in the large dining rooms of the central hall, rest and quiet is to be the feature of life in the Cottages, and recreational activities are to be centered at the Field Club. The present construction plan provides only for the three cottages nearest the Hall, but the service facilities of the Hall and the Field Club can be readily expanded to meet the needs of three additional cottages as yet unauthorized by the board of trustees.

An interesting and important feature of the plan is that the Cottages and the several units of the Hall group, although apparently independent, are all connected by a broad terrace in front, underneath which is a cloistered way through which guests and employes may go in comfort from one building to another in inclement weather. A pipe gallery is also conducted beneath this terrace at a still lower level, through which will pass all lighting, heating and drainage lines, thus making maintenance and repair easy at all times. This cloister will, it is believed, add much to the comfort of guests, particularly in winter, and will at the same time make for economical operation and maintenance. Its course under the terrace will follow closely the natural contours of the hillside and will unquestionably add to the appearance of the buildings.

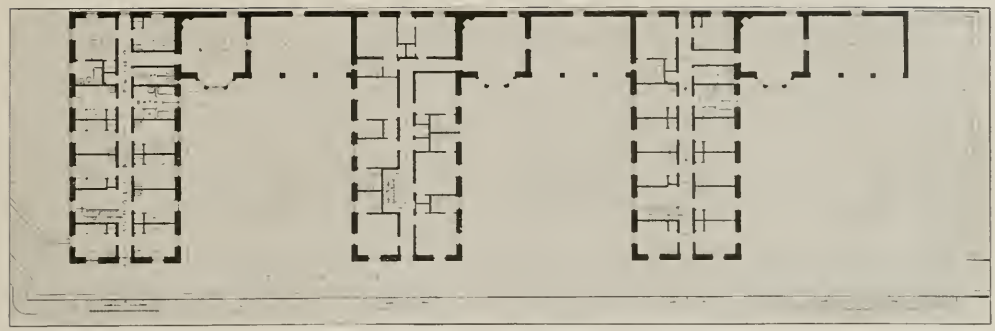
The Hall group, the main floor plan of which is exhibited, will include the hall, or major central unit, of three stories and basement, a connecting guest cottage wing of two stories and basement extending toward the lake, and a connecting employes' residence wing of three stories and basement extending to the east along the mountain side. The kitchens, storerooms, engine rooms, laundry, garage and machine shops are all accessible from a service court at the rear of the Hall and also, through the cloister previously mentioned, from the cottage group. The guest cottage wing and the employes' residence wing,



Plan of Field Club, Valeria Home

although integral parts of the Hall group, will be practically independent cottages, each having an attractive outlook on the lake and hillsides and excellent exposure to the sunlight.

The Hall will contain a guests' lobby or lounge, the executive offices, library and reading room, a few private rooms and suites for guests and executives and the general dining rooms, kitchens and general service accommodations for both guests and employes. The heating, lighting, refrigerating and incinerating plants will be in the



The main floor plan of the Valeria Home Cottages.

basement of the Hall and well below ground, so as to minimize noise. The guest cottage wing will contain only private rooms for guests and executives, and the employes' residence wing only private rooms and sitting rooms for employes other than executive officers. The residence capacity of the Hall and its two connecting cottage wings will be approximately sixty-two guests and executive officers and forty-nine domestic employes.

Cottages Will House 74 Guests

The cottage group, each of two stories and basement, now under construction, has been so planned as to permit segregation of the sexes as to cottages and, at the same time, reasonable freedom of social contact between them. Each cottage has its own porch and sitting room looking out upon a lawn which slopes lakeward to the terrace passing along the front of the cottages. These porches and sitting rooms serve as connecting links between adjacent cottages, but the connection will not be an obvious one because the porches and sitting rooms are only one low story in height. The effect when the cottages are viewed from below at the lake level is of independent cottages, the roofs of the connecting porches and sitting rooms not being visible. As now planned one cottage will be used for men only, one for women only and the third for married couples. This scheme of segregation is not essential, however, for satisfactory use of the cottages, as all cottage accommodations have been designed to make possible any necessary adjustment of housing to meet the need of the moment. The cottages for men only and women only will each provide accommodations for twenty guests in individual private rooms and for two guests in one double room which may, if circumstances require, be used as a house officer's residence. The cottage for married couples contains fifteen double rooms. The total capacity of the three cottages is, therefore, seventy-four guests.

The third, or Field Club group, which is situated on high open ground on the west shore of the lake and about an eighth of a mile away from the central Hall group, comprises a clubhouse of two stories and basement, with a connecting outdoor swimming pool 35′ x 70′ in size and a boat house on the lake edge. The club house will contain a large entertainment hall, lounge, refreshment room, game room, accommodations for four guests or executive officers, lockers, store rooms, tub and shower baths and all the usual facilities of a country club. The cleared ground about the Field Club group is well suited for tennis courts, short golf courses, lawn bowling, etc., and the lake where boating, fishing and bathing may be enjoyed is close at hand.

Lends Itself to Expansion

The total capacity of the Valeria Home, in the Cottages, the Hall group and the Field Club, will be 149 guests and executive officers and forty-nine domestic employes. It will be apparent to one with experience in institutional construction and operation that the service facilities, particularly those of kitchens and dining rooms, are in excess of the requirements of this number of guests and employes. It should be said, therefore, that all space and equipment has been so planned that it may be adjusted to meet conveniently and economically present needs, and may, without new construction, be readjusted satisfactorily when capacity shall be increased by the addition of more cottages. For example, the dining room space shown in the drawing of the Hall group will, for the present, be divided in half by a removable glass partition, so that that part which is adjacent to the entrance hall may be used as a general assembly or lounge.

Guest rooms, with the exception of the fifteen rooms intended for married couples and a few double rooms, designed primarily for executives, will be single rooms approximately 9′6″ x 12′.

Double rooms will be approximately 12′ x 12′. Effort has been made in planning rooms to have them large enough for the convenience and comfort of guests and yet so small that it will be impossible to crowd them with more than the proper number of persons. Each individual private guest room will be comfortably furnished, with ample closet room, and provided with set basins with hot and cold water. Employes' rooms will be for the most part individual rooms, approximately 8′ x 12′, and similarly equipped. The double rooms which have been provided for married couples and executives will have connecting private baths. An adequate number of toilets, tubs and shower baths will be provided on all floors of all buildings for the use of guests and employes.

The water supply of the Valeria Home will be obtained from deep driven artesian wells and will be ample for all possible service requirements now and in the future. A complete and thoroughly modern sewage disposal system will be installed, sufficient in size to care for all possible increases in service. The buildings will be electrically lighted and steam heated and all equipment will be of the most modern type. Farm operations, such as fruit and vegetable gardening, dairying, poultry raising, etc., will be undertaken only as experience demonstrates such operations to be necessary for the comfort and welfare of guests and an aid in the economical maintenance of the Home.

Since the Home is designed for year round service, special effort is to be made to make the winter season attractive. The lake and its surrounding hills are well situated for outdoor recreation in winter and all manner of winter sports will be developed as rapidly as possible. It is the intention of the board of trustees to pattern its winter program somewhat after that of the Lake Placid Club in the Adirondacks, which has been so successful in making its winter service quite as attractive as that of mid-summer. The Valeria Home will, however, keep in mind particularly the needs of convalescents. Few natives of New York realize the charm of winter in the country and the vacations of most workers of the group for which the Valeria Home is designed are taken in the summer. It is believed that when the plan of winter rest and recuperation has once been tried, many workers will find life in the country even more pleasant and beneficial to health in winter than in summer. It is hoped, too, that employers in many lines of business will find it possible to adjust their work so that their employes may obtain rest and recuperation when needed, whether in winter or summer.

The Valeria Home summer camp, which has been in operation for the past three summers, will be continued for summer service during the construction of the larger buildings and, if experience warrants, will be utilized to take care of the summer overflow from the larger institution. The summer camp is an attractive two-story building with accommodations for thirty-five guests in individual rooms. Thus far only women workers have been received at the summer camp, and during the three years of summer service over 1,000 business and professional women guests have been entertained for periods varying from a few days to a month or more. The success of this service, which has been furnished at the rate of $8.50 and $12.00 per week, depending upon the selection of rooms, apparently indicates that no difficulty will be experienced in securing a satisfactory clientele for the larger institution. The difficulty will, we hope, be rather that of providing sufficient accommodations for all who need it and want it.

The Valeria Home represents the practical application of the ideal of the founder, Mr. Langeloth, according to the carefully thought out plan of the board of trustees, arrived at after months of study of the needs of those for whom it is intended. Its success in meeting those will, in the last analysis, depend largely upon the cooperation of physicians and private and public health and social welfare organizations having a similar interest. The objective of the Valeria Home service is essentially the prevention rather than the cure of sickness, in other words, preventive convalescence in pleasant surroundings and, with the aid of simple natural remedies, good food, rest and recreation suited to the particular needs of the individual. No special therapeutic equipment is to be provided, and only such supervision of individual action as is necessary to make group life happy and healthful.

RECEIVE PRAISE FOR FIRE PROTECTION

Authorities of Mary Immaculate Hospital, Jamaica, N. Y., take pride in the safety of their building from fire hazards. In addition to a hospital building of brick and stone throughout, the institution retains the American Fire Service Corporation, of which Edward F. Croker, Jr., is the head, to conduct fire drills from time to time and to instruct all attaches of the institution in what to do in case of emergency.

The following letter from Mr. Croker, president of the company, under date of October 4, shows the high state of efficiency the hospital staff has gained.

"Desire to report that our supervising drill inspector, Capt. Charles Unbekant, visited your premises on the 2nd inst., and conducted a drill of your employes, which was entirely perfect. Signal was sent from third floor and brigade and nurses responded promptly; brigade stretched line and carried extinguisher. All placed and ready for service in 34 seconds. Nurses responded in large numbers. Splendid cooperation between Sisters, nurses and brigade."

THE PROPER INSTITUTIONAL CARE FOR PATIENTS WITH CHRONIC DISEASES

By ERNST P. BOAS, M.D., Medical Director, Montefiore Hospital for Chronic Diseases, New York, N. Y.

THE problem of the hospital care of the patient suffering from chronic or so-called incurable diseases has barely been touched upon, in spite of the great progress that has been made in the standards of the general hospitals within the last thirty years. The reasons for this fact are manifold, and it shall be my endeavor in this article to stress the important factors involved in the care of chronic patients and to suggest a partial solution of the problem.

It will be well to define what is meant by the chronic patient. In short, he may be described as one who requires hospital care for a period of from three months to several years. The reason for his prolonged hospitalization may be medical or chronic. In many diseases the complete or partial rehabilitation of the patient may require months of treatment. Furthermore, there are many patients rendered helpless by their disease, who need skilled nursing care but little medical attention, who cannot be taken care of in their homes because of unfavorable home surroundings. Finally, there are those disabled by some ailment who require no expert treatment but who are homeless. The following are among the most important diseases which may compel a patient to seek institutional care: organic disease of the heart, arteries or kidneys, chronic arthritis, diabetes mellitus, carcinoma, hemiplegia, organic nervous disease of all kinds.

There is another phase of the problem that is very important. Seventy years ago the so-called "chronic diseases" caused about one-fifteenth of the total number of deaths. Today they are responsible for one-half of all deaths. Scientific study of these diseases can be pursued only in an institution and is urgently needed. It offers probably the most fruitful field of research during the coming years. It becomes the duty therefore of every institution that cares for the chronic sick not alone to harbor these unfortunates after the disease has run its course, but also to be equipped to study the causes of the chronic ailments of mankind with a view to prevention.

A little reflection will call to mind how great is the number of individuals who are incapacitated by such diseases and how vast is the problem of their proper institutional care. On June 30, 1920, of the 9,107 patients in county, state and town almshouses in New York, 59.1 per cent were sick or infirm, 23.3 per cent able-bodied, and the rest either blind, deaf, feeble-minded or epileptic.

In the past most of the chronic sick have drifted into almhouses, together with the aged and paupers, where there are few facilities for their proper care. It is true that within the past fifty years hospital wards have been established in connection with most almshouses, and that many homes for incurables have been founded, but they too have been and are, for the most part, purely custodial in nature and have done little more than provide for the most elementary needs of these invalids who wait for death to release them from their miseries.

The problem of the proper care for these unfortunates is an old and a perennial one. In 1884 the New York State Charities Aid recommended that no feeble, intemperate or unqualified person should be allowed to nurse the sick, and that at least one good nurse be employed in every poor house. In the same year a training school for nurses was established at the Blockley Almshouse in Philadelphia. Yet, in 1919, in the report of the State Board of Charities of the State of New York, we find the statement: "Such complaints

"One-half of the deaths in the community are attributable to chronic diseases. The scientific investigation of these diseases and the adequate care of those afflicted with such ailments is one of the crying needs of the time. More hospitals for chronic disease, which will admit patients for periods of from three months to several years, should be established. Such hospitals must be equipped with all of the facilities of a general hospital. They should retain in their wards only such patients who need active medical and nursing care. In connection with such hospitals there should be a separate pavilion for purely custodial cases. A method of free transfer between the two departments of the institution should be established. A home for incurables should have no independent existence without immediate access to complete hospital facilities."—Dr. Boas.

show that the superintendents of these homes for the aged and infirm need the assistance of competent and conscientious nurses, orderlies and other attendants, that the dependent wards of the city may be assured adequate care."

In England the development has been much the same. An order of the poor law commissioners in 1847 states that "any able-bodied woman or girl might be employed constantly or occasionally in any of the female sick wards; and any infirm woman, whom the master of the workhouse might deem fit to perform any of the duties of nurse, might be so employed in any of the female sick wards; any male infirm inmate, whom the master might deem fit, being likewise employed in the male sick wards." Some years later the inadequacy of such provisions was realized and the Workhouse Infirmary Nursing Association secured radical improvements in this respect and between the years 1879 and 1889 supplied 92 trained nurses to different infirmaries. Even before this, in 1865, Miss Agnes Jones and twelve nurses from St. Thomas' Hospital undertook the nursing at the Liverpool Workhouse Infirmary and became pioneers in the scientific nursing of sick paupers.

Ice Cream in Place of Medical Treatment

At the present time, as I shall endeavor to show in a survey to be published later, very few of the institutions devoted to the care of sufferers from chronic diseases have the organization and equipment to carry on their work properly. In most of them the staff of physicians and trained nurses is very inadequate, laboratory facilities are lacking, and the policy of the institution is not guided by a medical and community point of view. A lady board of managers, with little appreciation of medical problems, guides the destinies of too many of these homes. The result of such an administration is found in the great attention that is paid to ice cream treats and amusements for patients, and the scant consideration that is given to important medical policies.

The slow progress in providing adequate care for incurables and for those suffering from chronic ailments is due largely to misconceptions as to the nature of their diseases and as to the treatment which they require. From the point of view of institutional care these patients may be grouped into three classes:

Class A. Those requiring medical study for diagnosis and treatment.

Class B. Those requiring nursing care only.

Class C. Those requiring custodial care only.

The management of each of these groups is a problem in itself and each class places different demands on the institutional resources. To clarify this point it may be well to cite a few examples of cases which fall into the different categories.

Thus, a patient with advanced organic heart or kidney disease, who may require many months of hospitalization, or a patient with an inoperable carcinoma, which may still yield symptomatically to proper treatment with x-ray and radium, falls in Class A. All of the facilities of a general hospital are needed to give adequate care to such patients. A patient with paralysis of both lower extremities, due to some incurable process involving the spinal cord, needs little medical treatment but requires careful nursing. In the same group fall the senile patients who are incontinent and who are, in other ways, unable to serve themselves. These patients fall in Class B. It is not enough to provide them with partially trained attendants. Their nursing must be painstaking and skilled to prevent bedsores and other complications. Catheterization and other technical nursing procedures are often demanded; the onset of pneumonia or some other complication must be watched for. Finally, in the custodial group must be classed patients with early multiple sclerosis, paralysis agitans, compensated heart disease or some other affection which is not completely disabling. They do not demand expert nursing. Sympathetic attendants under skilled supervision are adequate to provide them with proper care.

A most important fact to recognize is that patients do not remain in one class indefinitely. Thus a patient may be admitted in Class A and in the course of months improve sufficiently to become a purely custodial case. This happens very frequently. On the other hand, it is just as common for a patient in Class B or in Class C to develop some complication or exacerbation of his illness which puts him into Class A. The fact cannot be overemphasized that the type of treatment demanded by the different groups varies considerably. The proper care of a Class A patient demands a complete hospital organization with a resident staff, an attending staff on which all of the specialties are represented, complete laboratory, x-ray and operating room equipment and skilled nursing and dietetic management. Class B patients require much less specialized attention but should command an excellent nursing service, controlled by a conscientious medical staff. Class C patients need the least care. As the classification implies, their treatment is largely custodial in character and they are retained in an institution not because they require hospital care but because the economic surroundings at home are such that they cannot be taken care of by their families. All of their wants are supplied by proper sleeping and living accommodations and food, with due regard to their respective dis-

abilities. Thus, many will require wheel chairs and all of the structural institutional facilities that that implies, and many will need the assistance of attendants in dressing, bathing and eating.

At the present time most "incurables" and patients with chronic diseases are taken care of in municipal institutions or in private homes for incurables. The municipal institutions largely partake of the nature of homes and derive their patients from the municipal and general hospitals, which transfer to them patients whose hospitalization is prolonged and who no longer interest them. Many of these still are Class A or B patients, yet the vast majority of the institutions which receive them are not prepared to care for them properly. A patient, once admitted to such a home, vegetates there until he dies and little or no attempt at rehabilitation is made. This may be readily ascertained by a comparison between the per capita cost of such an institution and of a general hospital. It should cost almost as much to give adequate service to Class A and Class B chronic patients as to patients with acute conditions. On the other hand, it is a wanton waste of funds to care for a custodial case in an institution which is equipped to handle the sicker type of case.

Evolution of Chronic Disease Hospitals

It may make matters clearer to consider the historical development of a hypothetical hospital for chronic diseases. It has been founded years ago by well-meaning philanthropists to provide a permanent home for a group of invalids whose miserable home surroundings make their institutional care necessary. Every case is carefully investigated before admission by a committee of the directors and personal contact is kept with the patient after his admission to the home. It is the social and economic aspect of the case which is the predominating one. A doctor is appointed as visiting or resident physician to the home. If he is at all conscientious he finds that many of the inmates present very interesting and difficult medical problems which he cannot handle alone. On his recommendation, more physicians are added to the staff. The medical staff devotes more and more time to the institution and makes ever increasing demands on the directors. As the patients are more carefully studied, accurate medical records must be kept, a laboratory must be established for routine diagnosis, an x-ray department is found necessary, and so the development goes on in all phases of the hospital's activities.

At first the patients were cared for by attendants or practical nurses, possibly under the direction of a graduate nurse. As the medical activities of the institution expand, more competent nursing service is demanded and more and more graduate nurses are employed. With a wide-awake board of directors and an active medical staff, the institution, which started as a simple custodial home for incurables, develops in a few decades into a highly organized hospital which is capable of handling all of the diagnostic and therapeutic procedures that are employed in a general hospital. The institution has learned that although this is expensive, it is the only safeguard against the maltreatment of patients. If a patient suffering from a chronic disease develops pneumonia, as happens so often, the institution must provide him with expert nursing and medical care. Many a hemiplegic and many a patient with arthritis deformans, who is bedridden, can be made to walk if given the proper mechano-therapeutic treatment. Occasionally it happens that the doctors discover that some patient, admitted as a paralytic, has a spinal cord tumor or a brain tumor and that an operation will relieve these symptoms and restore him to health. It is bad psychology and bad medical practice to call a patient "incurable." It results inevitably in sloppy treatment and neglect, and takes for granted more knowledge than a physician has a right to arrogate to himself.

Let us imagine that an institution which cares for chronic patients has passed through the development sketched above. It has all of the facilities of a general hospital adapted, however, to the particular needs of its patients. When we analyze the type of patient in such an institution, we find inevitably that although there are many patients who fall in our Class A and B, who require this expensive care, there are others who belong to the purely custodial class. It is a waste of funds to house such custodial cases in a costly hospital plant, for they do not need intensive medical and nursing care, they do not need the other resources of the institution, such as the laboratories and the other special departments. Their need is primarily economic. They require a home, yet, before they can safely be classed as custodial cases, they will require careful study and the use of all of the facilities that the institution has at its command. After they have been declared custodial cases, they may at any time develop an acute complication which renders skilled medical and nursing service imperative.

Separate Building for Custodial Cases

They should therefore be housed in a separate building especially designed for their care, where they can be made comfortable and cared for at a minimum expense. The main institution should be reserved for patients who require the special-

ized facilities of a hospital, and for whom there is some hope of rehabilitation. In charge of the building which houses the custodial cases there should be an experienced graduate nurse and a physician from the main institution should visit the home periodically. A free method of transfer between the main institution and the home should be established. When a custodial case becomes ill, he should at once be returned to the main institution. When a patient in the main institution no longer requires special hospital care and cannot be discharged because of his poor home surroundings, he should be transferred to the custodial institution. No patient should be admitted directly as a custodial case without first having passed through the careful routine of the hospital. Such an organization will avoid the evils which are inevitably bound up with the present homes for incurables and will, at the same time, avoid the unnecessary expense of maintaining custodial cases in an institution designed for the care of hospital patients.

TUBERCULOSIS TRAINING FOR NURSES

It is small wonder that so many nurses are afaid to come near or give attention to a case of tuberculosis.

Many studies have been made to show that the average nurse, like the average doctor, gets little real knowledge of tuberculosis from first-hand contact during her two or three years of training. It is only by actual experience and training in tuberculosis work that the fear of the disease is overcome and the methods of protecting one's self and others really mastered. No one is so fearful of tuberculosis as the person who has never been inside a sanatorium. Additional light on this problem has been thrown by a recent study of training schools in New Jersey made by Miss Virginia M. Chetwood.

Miss Chetwood received replies from 26 of the leading hospital training schools in the state in response to a questionnaire that she had sent out. Only one school of the entire 26 gives any regular ward training in the care of tuberculosis to its nurses. Eight of the 26 never receive any cases of tuberculosis, refusing them admission to the hospital. In seven of the schools a certain amount of clinic service ranging from four to eight weeks is given. Seventeen of the 26 give lectures on tuberculosis, the remaining nine giving no instruction either by word of mouth or by clinical demonstration to any of its nurse pupils. In only five cases were lectures given by physicians competently trained in tuberculosis. Only 11 of the training schools were willing to affiliate with nearby tuberculosis sanatoriums for the training of their pupils nurses, although in 18 instances such institutions were in close proximity. Of the 15 who were unwilling to make such affiliation 8 of them gave as a reason that they were short of nurses.

It is a sad commentary upon nursing education that hundreds, nay even thousands of young women, are graduated apparently as full-fledged nurses every year without any practical knowledge of tuberculosis, the most prevalent and dangerous disease in the country. It is disheartening to note the attitude of managers of such training schools in refusing to avail themselves of ready-made facilities for training nurses because of the expense involved.

It is to be hoped that as the result of the Rockefeller Foundation study of nurses training schools those institutions that refuse to train nurses as they should be trained will be compelled by public demand to find some other way of getting their nursing done. It is high time that our training schools for nurses were taken out of the category of agencies that exploit their pupils for pecuniary advantage.—*Journal of Outdoor Life.*

STANDARDIZING CLINICAL LABORATORIES

Four general standard requirements for clinical laboratories are enumerated by Dr. Josiah J. Moore of Chicago, in an address on "Standardization of Clinical Laboratories" delivered before the section on pathology and physiology at the last annual session of the American Medical Association. The paper is published in a recent issue of the *Journal of the American Medical Association.*

These requirements represent Dr. Moore's own thought on the subject and the suggestions of a large number of laboratory directors and pathologists to whom they were submitted. As enumerated they are:

1. The director of a clinical laboratory should be a medical graduate.

2. All interpretations of laboratory data should be made by doctors (of medicine, philosophy or public health) who are specialists in the branch of work to which the data pertain, i. e.:

(*a*) Serologic, bacteriologic and chemical interpretations should be made by doctors who are trained serologists, bacteriologists and chemists.

(*b*) Tissue diagnosis should be made by doctors of medicine who are experienced pathologists.

3. Technical procedures (methods) used in an acceptable laboratory should be the best available: those used and approved by authorities.

4. The equipment of an acceptable laboratory should be such that the proper technical procedures may be carried out. There should be ready access to current scientific books and journals.

With reference to these suggested requirements, the following statement is made:

1. The director of a laboratory should be able to act as consultant in evaluating for his clients the various laboratory reports and in correlating them and other clinical data.

2. Many technical methods—most of them, perhaps—may be satisfactorily carried out by technicians. The data derived by such methods, however, should be interpreted by specialists.

3. If it is insisted that only the best modern methods be used in a laboratory, it follows that the technicians employed must be trained in these methods.

4. Clinical data and other pertinent information should accompany the submission of specimens or other material to the laboratory.

As the methods of standardizing clinical laboratories, Dr. Moore mentions several agencies, none of which pleases him. His general conclusion is that a combination of such agencies should undertake the work.

A method of state control of public health could be adopted in each state, but there would surely arise the same difficulties we now have with the multiplication of state boards of medical examiners.

A more general system of supervision appears desirable, and this may be accomplished by having the hygiene laboratory of the U. S. Public Health Service act as a central authorized body.

HOSPITALS OF COLOMBIA

By JORGE CAVELIER, M.D., Chicago, Formerly of Bogota, Columbia.

A STUDY of the hospitals of Colombia ought to include not only the description of those institutions that exist at present, but a consideration of the projects that today are developing in conformity with advanced medical science. What these hospitals will be in the near future depends on the economic development of Colombia.

In this article we will study three phases of hospital conditions and what is said here will apply to all the hospitals of the republic as almost all of them are confronted with the same problems.

There are two classes of hospitals in Colombia, those which are organized and maintained by the government and those organized by individuals who give their services to society and at the same time ask some remuneration from patients.

The first class, or the public hospitals, at all times receive some donations from charitable persons who wish to contribute to the betterment of these establishments. The Hospital de la Misericordia (Mercy Hospital) of Bogota will serve very well as an example. The building was bequeathed by Dr. Ignacio Barberi for the treatment of children's diseases and the government pays for the current expenses of keeping it up. There are many such cases as this.

Public hospitals are known as "Hospitales de Caridad" (charity hospitals) and can be found in every city and town of Colombia, generally under some such name as "Hospital de San Juan de Dios" (Saint John of God Hospital) of Bogota, "Hospital de San Vincente" (Saint Vincent's Hospital) of Medellin, etc. The department governments or the municipal governments maintain them but the national government contributes considerable amounts of money for the running expenses of many. Administration generally is by a board known as "Junta de Benèficencia" (public welfare board) which is composed of persons of wide reputation who donate their services.

The buildings which the charity hospitals now occupy are inadequate; the majority of them are similar in construction, having been built during the Spanish colonial period. It is impossible in many instances to change or remodel details to conform with the present rules of hygiene, and the only remedy is to build entirely new buildings.

The Charity Hospital of Bogota, called San Juan de Dios, has undergone various changes lately which have improved its hygienic and esthetic conditions. It now has wards for gynecology and maternity cases, which fill that need fairly well, but it also is of Spanish construction and does not meet with the requirements of a modern institution.

As to the equipment of these hospitals, it is far from satisfactory; only a few of them possess the instruments and apparatus needed for the practice of the various specialties into which modern medicine and surgery are divided. The "Hospital de San Juan de Dios" of Bogota has complete x-ray equipment; naturally it makes the hospitals in other cities of Colombia realize the importance of such apparatus.

A sanitary station at the port of Colombia.

These hospitals for the most part must receive patients with every kind of disease; a few of them located in the principal cities are dedicated to a single specialty only. For instance in Bogota there are the "Hospital de los Alisos" for the treatment of smallpox and "Hospital Misericordia (Mercy Hospital) for children's diseases. The Hospital for Mental Diseases, which also is in Bogota, has separate buildings for men and women and is known as "Asilo de locos y Asilo

Hospital de San Juan de Dios at Cucuta.

de locas" (Insane Asylum for Men and Women). There is also in Medellin an institution for mental cases only.

In the various departments, there are what is called "Dispensarios" (dispensaries) which are devoted to the prevention of venereal diseases by administering the proper treatments in these cases. The most important of these are "Dispensario de Cundinamarca" (Cundinamarca dispensary) which is located in Bogota; "Dispensario de Girardot" (Girardot dispensary) in the city of Girardot, and the dispensaries of the cities of Medellin, Cartagena, and Cali. Bogota also has a municipal clinic for venereal diseases which is maintained by the municipal government.

The national government maintains for the treatment of leprosy three leper colonies, where are isolated all those afflicted with that disease. They are known as "Leprosario de Agua de Dios" of Cundinamarca, "Leprosario de Cano de Loro" (Cano de Loro leper colony) in the department of Bolivar and Leprosario de Contratación in the department of Santander. Each one of these colonies attends the sick free of charge. Their administration is under the "Direccion General de Lazaretos" which has its offices in Bogota. At present Dr. Alejandro Herrera Restrepo is in charge of it.

There are institutions called asylums for old people and for the development of the abnormal in the principal cities; for instance the Old People's Asylum in Bogota, the Asylum for the Poor of the same city, and many similar institutions in Medellin, Cartagena and others.

These public institutions are under the management of a board of citizens, known as the "Junta de Benèficencia" (public welfare board), and they are empowered by the government to decide on all questions which may come before them regarding free hospital service. In Bogota all these municipal institutions are under the direction of the "Junta General de Benèficencia de Cundinamarca (general public welfare board of Cundinamarca) which is in full charge of all matters pertaining to the general management and president of which now is Dr. Francisco Samper Madrid.

Private Hospitals Are Called Clinics

Regarding the private hospitals which are found in many cities of Colombia and are owned by physicians or companies, patients are required to pay for the attention received there. They are generally called clinics or "Casa de Salud" (health homes) and a few of them are called hospitals.

In Bogota, the following are of that class: the well-known Dr. Pompilio Martinez' Clinica Quirurgica (surgical clinic) which has recently been built in accordance with all modern requirements, and where only surgical cases are received; the Casa de Salud de Marly (Marly health home) located in the suburbs of Bogota, where both surgical and medical cases are treated, its head physician is the notable Dr. Carlos Esguerra, and its surgeon, Dr. Zoilo Cuellar Duran; the Clinica de Santa Lucia (St. Lucy's Clinic) maintained by Dr. Manuel Antonio Cuellar Duran, where only eye, ear, nose and throat diseases are treated. Next to this latter clinic, there is a pavilion for gynecology cases treated by the celebrated specialist of Bogota, Dr. Rafael Ucros; Dr. Manuel V. Pena's "Casa de Salud" (health home) is located in the center of the city and is for patients who need surgical and medical attention; the "Casa de Salud del Campito" maintained by the Sisters of Charity is devoted to the treatment of mental and surgical cases.

The other cities of Colombia also have private institutions, such as: the "La Samaritana" (The Samaritan) of Medellin, which is conducted by Dr. Montoya y Florez; Dr. Luis Garces' Clinic in the city of Cali; the Doctors Gomez Sanchez and Lemus y Rodriguez' Clinic and Dr. Calvós Casa de Salud in Barranquilla; the Casa de Salud which has just been opened in Cartagena by some of the best physicians of that city, together with a United States physician, Dr. Pernett y Cordoba as the principal organizer. In Cumbre, a town in Valle del Cauca near the city of Cali, there has been for some time, a sanitarium maintained by United States physicians.

Dr. Julio Zuluaga has just opened his clinic in Manizales; the United Fruit Company has constructed a modern hospital along American lines in the city of Santa Marta and it is for the use of the laborers in the banana zone who may wish to go there. The Tropical Oil Company recently built a hospital in the town of Barrancabermeja in the department of Santander which is for the use of its employes in the petroleum fields.

Equipment Conditions Vary

The condition of these private hospitals, as to the buildings they occupy and the equipment they have, varies. Some of them have been recently built on the general plan of a hospital adhering to the rules of hygiene, and offer all the modern conveniences, such as Dr. Pompilio Martinez' "Clinica Quirurgica" (surgical clinic) in Bogota; Dr. Calvós "Casa de Salud" in Barranquilla; the United Fruit Company Hospital in Santa Marta and others. The rest have utilized buildings not especially constructed for hospitals, but having been remodeled, they are able to give fairly good service. As to the equipment, some are completely outfitted with all apparatus and instruments for examining and treating all classes of diseases, but there are others which are very deficient in this regard. The proprietors realizing their lack try hard to acquire all necessary equipment that up-to-date medical science demands. We will find in all the cities and towns of Colombia that the people have come to realize that the possession of hospitals which comply with the principles of hygiene and have all the known modern instruments and equipment for the diagnosis and treatment of all diseases, not only ought to be, but are a real necessity in the 20th century. Unfortunately the economic situation of the country does not permit us to advance in this work as rapidly as one would like. However, the country is now beginning to give freedom to its energies and is giving some of its wealth to institutions which care for those in need. Considering the bad situation of the country great projects have advanced as the result of the individual and government initiative.

Surgical Society Builds Modern Hospital

As the reader can appreciate, after having read the previous paragraphs, there is not a large modern hospital in the city of Bogota, the capital of Colombia, but two are now nearing completion. Colombia hopes in these two to have her first thoroughly up-to-date hospitals. One of these two institutions is a result of the efforts of the "Sociedad de Cirugia" (surgical society) of Bogota and the other has been built at the instigation of the "Junta General de Benèficencia" (general welfare board) of Cundinamarca. The two hospitals are intended to be charity hospitals and replace the present charity hospital, San Juan de Dios.

The "Sociedad de Cirugia" (surgical society) of Bogota is an association of a scientific nature and is composed of the most renowned physicians of the country. It was organized for the purpose of building a hospital, with a rather large capacity on the pavilion plan, pavilions for different diseases being completely separated, but all opening on a central pavilion. All the most modern conveniences are found there and all in accordance with the rules of hygiene. There are various operating rooms and it has the services indispensable for the correct practice of medicine and surgery, such as x-ray laboratories, bacteriological laboratories, etc.

The "Junta General de Benèficiencia" (general public welfare board) of Cundinamarca, with offices in Bogota, has started to build a hospital of large capacity for the purpose of replacing the present Hospital de San Juan de Dios. It will be known under the same name, "San Juan de Dios."

With these two public hospitals both of a large capacity, Bogota which has a population of 200,000 inhabitants will be sufficiently provided with such institutions for the present.

Colombia is a country endowed with enormous natural wealth. In its soil are found the richest emerald mines of the world, gold, silver, copper, iron and many other minerals. Platinum is extracted in large quantities in the Choco region; there is petroleum in all parts of the country, and a great part of the territory produces coffee, cocoa, bananas and many other food products.

Besides its position on the Panama Canal, Colombia has both Atlantic and Pacific ocean coasts, making its location enviable for the development of its wealth and the exporting of it, at little cost to all parts of the world. Unfortunately its wealth has been unexplored and it is only now that some companies have begun to develop and are supported by either national or foreign capital; both together are placing Colombia in an economic position truly enviable.

The approbation of the treaty with the United States by which Colombia will receive the amount of $25,000,000 will be another means for Colombia to prosper and consequently to increase the wealth of its inhabitants. With the economic perspective of Colombia so brilliant, it is natural to suppose that the construction of modern hospitals and their equipment will be called to the attention not only of the government, but also of individuals. Even today they are taking great interest in this subject.

THE ONLY NATIONAL LEPROSARIUM IN THE CONTINENTAL UNITED STATES*

By C. H. LAVINDER, M.D., Surgeon in Charge, U. S. Marine Hospital, No. 21, New York (Stapleton), N. Y.

EFFORT on the part of those interested in lepers to have established in the United States a national leprosarium for the care of these unfortunates culminated during 1917 in the passage of legislation on the part of Congress, appropriating the necessary funds for the establishment of such a place. This leprosarium, in accordance with the legislation, was to be operated by the United States Public Health Service.

A drawing of the national leprosarium at Carville, La., as it is planned eventually to accommodate 500 lepers.

Subsequent to the passage of this legislation, there followed an earnest search on the part of the Public Health Service to find a suitable location for this place. Difficulties of all kinds were encountered, chiefly strenuous objection on the part of any locality to the existence of such an institution within its borders. Finally, after nearly three years of effort, negotiations were completed with the state of Louisiana to purchase a state leprosarium, which had been in operation many years at Carville. The title of this place was finally transferred to the United States government in 1920. At that time, there were in this institution eighty lepers.

Frame-stucco quarters recently erected for the medical officer in charge.

The legislation carried a total appropriation of $250,000. As soon as the title to the place had

*Approved for publication by the U. S. Public Health Service.

passed to the national government, the Public Health Service immediately undertook to expend this money in improving the place and extending its facilities, with the result that there is now available a total of about 200 beds.

The patients' quarters at the national leprosarium.

The establishment of a national leprosarium in the continental United States is a matter of some significance in public health. It is not known how many cases of this disease exist on the continent. Various estimates have been made, ranging from 500 to 1,200. The probability is that somewhere between these extremes will be found the truth.

Leprosy, as is well known, is an ancient disease characterized by marked chronicity, with many repulsive features, and, since the days of Moses, has borne a sinister reputation in the lay mind. It is curable with difficulty and there exists need of prolonged care, since the average duration of this disease is many years. Cures do take place, however, and patients from leprosariums are frequently admitted to parole, while under observation, for two years or more.

Leprosy is an infectious disease, the specific organism being well known. Its method of spread is uncertain. It is well known however that the disease, once introduced into a community, does slowly spread involving after many years not a few of those persons who come into intimate contact with others afflicted with this infection. It has also been shown, as would be expected in a disease of this character, that careful collection and segregation of all the infected ultimately results in the disappearance of the disease from the country where such precautions are properly carried out.

Disease Advances Slowly But Steadily

Of course, in mere numbers leprosy from a public health point of view is almost a negligible quantity, at least so far as the United States is concerned. This statement, however, is true only for the present time. Should a disease of this character be permitted slowly to progress, no one can doubt that with the passing years leprosy, even in the United States, may become a question of serious public health importance. Its history in other countries has always shown a slow but steady advance. Of course, it should also be recognized that certain races appear to possess a relatively high degree of immunity to this disease, but the United States now harbors so many people belonging to almost all the races of the world that this particular point is a matter of comparative insignificance.

From every point of view, it is certainly the duty of this government to put into effect a policy with regard to this disease which ultimately will result in its disappearance, and this has been begun by the establishment of a national leprosarium where these sufferers can be placed in congenial and humane surrounding without endangering the health of this country.

The hospital grounds, as seen from the levee of the Mississippi River.

The leprosarium, which has been established at Carville under the Public Health Service, is known as United States Public Health Service Hospital No. 66. It has an extent of 380 acres.

It is located on the Mississippi River about 100 miles northwest of New Orleans and near St. Gabriel. The buildings which existed when the place was transferred to the national government have been remodeled and the place has been laid out on a plan which contemplates future developments. Several additional structures have been erected giving a total bed capacity of 200. Arrangements are made for the reception of both sexes, and for colored as well as white. Care has been taken to provide for the necessary housing and care of all patients. Of course, professional facilities have also been take care of and considerable attention has been devoted to the provision for recreational facilities. The religious tendencies of the patients have not been overlooked.

The administration building at Carville.

By reason of the long duration of this disease, such patients while under treatment are not so well cared for in ordinary hospital wards. The problem becomes one of combined domiciliary care and hospital treatment in the case of acute exacerbations or intercurrent illnesses, and the necessary infirmary is provided for these. The general treatment of the disease can be carried on quite satisfactorily without the necessity of actual hospitalization.

In the housing of the patients, experience has shown that it is far better to arrange for their housing in small groups, where persons of congenial temperament may be brought together. The new construction, therefore, will be found to consist of cottages caring for ten to fifteen people rather than large dormitories. Photographs and sketches will show the general layout of the institution and the character of the new construction.

The medical officer in charge of this institution is Dr. O. E. Denney, a reserve officer of the Public Health Service, who has had long experience in the care of lepers in the Philippine Islands, where there exists one of the largest leprosariums in the world. The collection of personnel for a place of this kind is by no means easy, since it involves more or less isolation and constant daily touch with persons who are suffering from what is, in many instances, really a loathsome disease.

It should be understood that the lot of lepers, if segregated singly or in small groups, is undoubtedly very harsh. When they are congregated, as in a leprosarium of this character, in larger groups, surrounded by good living conditions and treated with a broad humanitarian spirit, their lot becomes far less harsh, if not

Some newly constructed cottages for lepers.

actually comfortable and sometimes even happy. The spirit which exists among the inmates of this institution is excellent, and, if one were to visit the place, one would find a rather happy family living comparatively normal lives and indulging in useful labor and healthful recreation. This is the spirit, of course, which must characterize a place of this kind, if it be a success.

It is of interest to note that in the legislation establishing the national leprosarium it is also provided that the national government should undertake the collection and transportation of lepers and pay the expenditures involved. This is a point of some significance in view of the difficulties presented in the transportation of persons suffering from this disease, on account of certain laws and of the popular feeling in the lay mind concerning the possibility of the ready transmission of this and other infections. This makes necessary always special arrangements to meet these difficulties.

The size of this institution is inadequate to care for the needs. It should be extended to number at least 500 beds, in order to meet the demands which will undoubtedly be made upon the place. As soon as public health officers throughout the country learn that they may place their lepers in a satisfactory institution of this kind, search for these unfortunates will be stimulated, and they will be gradually collected and segregated to the interest of themselves and every community. At the present time applications for admission to this home exceed by a good deal the number of beds which can be supplied with present appropriations. It is believed that Congress will view this matter in a sympathetic light and undoubtedly will extend the facilities of this institution sufficiently to care for all of the demands.

NEW UNITED ISRAEL ZION HOSPITAL IN BROOKLYN OPENS

United Israel Zion Hospital, occupying the block between Forty-eight and Forty-ninth Streets at Tenth Avenue, Brooklyn, was formally opened on September 17. The hospital dispensary opened for the reception of patients the previous week.

This institution, said to be the most modern hospital in Brooklyn, will serve the residents of Borough Park, Bath Beach, Bay Ridge, Bensonhurst, Coney Island and Flatbush.

Among those who attended the formal opening of the hospital were Mayor John F. Hylan, Welfare Commissioner Bird S. Coler, Borough President Edward Riegelmann, U. S. Senator William M. Calder, Supreme Court Justices Edward Lazansky, Mitchel May and Harry E. Lewis, Judge Alexander Geismar, the chief, medical staff and officers of the synagogues throughout the sections the hospital will serve. The hospital can accommodate 175 patients. There are fifty-three private rooms and six public wards.

It was erected and equipped at a cost of $1,000,000. It possesses modern equipment and all the rooms face the sunlight. The general plan of the hospital is "H" shaped, ground at the northwest being left vacant for further construction as demands require. Each floor has its sun porch, facing south, where patient and bed may easily be wheeled.

The front pavilion contains the private service and the rear the public service. On each floor the pavilions are connected by corridors from which other wards and rooms open. A reception ward is provided, where patients will first be placed under observation for contagious and infectious diseases before being admitted to the proper ward.

On each floor, adjoining the wards, are isolation rooms where patients in distress or, who for other reasons would be disturbing to occupants of the same ward, may be transferred and placed under direct supervision of the nurse in charge. A labor room and delivery room, each of which is completely isolated against the transmission of noise, are located on the top floor of the building. Directly opposite the maternity ward is the nursery, which is sufficiently close to enable mothers to see the infants through glass sash. The ward, however, is far enough so that the infants cannot possibly disturb the rest of the mothers. The children's ward is particularly attractive with its large bay windows, facing south and with playrooms decorated with pictures and rhymes.

While the hospital is non-sectarian, all Jewish dietary laws have been conformed with in the laying out of the kitchens. Among the devices of modern equipment which have been installed are steam cooking apparatus, electric meat choppers, electric vegetable paring machines, electric and steam dishwashing machines, electric ice cream freezer and bread cutters.

Much care has been exercised in laying plans for the laundry so as to insure the utmost efficiency. To this end, modern devices of electrical and steam apparatus have been installed.

RED CROSS ROLL CALL BEGINS ARMISTICE DAY

The annual Roll Call of the American Red Cross, in which its membership is renewed from year to year, will take place in the period between Armistice Day, November 11, and Thanksgiving Day. This is the only appeal that the national organization makes during the year and is for the purpose of maintaining its membership at such a point as will enable it to perform those duties which are placed upon it by Congress.

For purposes of the 1922 Roll Call three posters have been prepared. One of these, "At the Service of All Mankind," is by Lawrence Wilbur, and another by Franklin Booth, the latter being a sketch of the Capitol on which is superimposed the Red Cross. The third poster, "The Planters," is for use in the Junior Red Cross Roll Call and is by Anna Milo Upjohn, the well-known painter of child subjects.

SOCIAL SERVICE IN THE STATE HOSPITAL

By HANNAH CURTIS, Director of Social Work, State Department of Mental Diseases, Boston, Mass.

POSSIBLY in no field is social service more necessary than in state hospital work. Patients confined in institutions of this type are frequently placed there without their knowledge or consent; their statements are often so colored or clouded by their mental illness that credence seldom is given to them; their social unfitness for community life is indicative of the need of special guidance; serious family situations often arise from the enforced commitment of heads of families. These and other factors clearly indicate the need of a group of specially trained people who may work in both hospital and community.

There are still various conceptions as to the real purpose and function of state hospital social service, although it is nearly ten years old in Massachusetts and is in process of establishment in other parts of the country. Several reasons might be offered in explanation of the lack of uniformity in development and interpretation, but a few may help to clarify or explain the rather indefinite statements which are occasionally made concerning this work.

Duties Are Widely Varied

Until recently all medical social work has been more or less vaguely understood and a great variety of activities, in many cases unrelated, has characterized hospital social work in general. It is quite generally acknowledged that social service must adapt itself to the individual needs of an institution; this being true, the very peculiar and varied needs of a state hospital for mental patients account in a large measure for the diversity of duties of the social service which, at times, are quite unrelated to the general principles of social work. In developing work of this kind it is important to note that the laws regulating the care and treatment of mental patients are not uniformly established throughout the country and customs and traditions relative to such patients must, therefore, be considered largely from local viewpoints. These and other factors which have a direct bearing upon public care of mental patients have doubtless added to confused thinking and cloudy interpretation of state hospital social work and have made it relatively difficult to offer concrete statements of the work with especial reference to its functions and values.

It is quite true that the early activities of practically all state hospital social service departments are diversified and in many instances unrelated to general principles of social work. It is equally true that wherever those activities have been carefully modified and directed into the proper channels, the real purpose and functions of this service have become clearly apparent and properly related to fundamental principles of hospital social work. As we are now emerging from the experimental stage of state hospital social service, it seems very important that special emphasis be laid upon the necessity of consciously establishing departments of social work in state institutions upon the recognized basis of all hospital social work, "assistance in the medical care and treatment of patients," otherwise its main purpose may ultimately fail of realization. In so far as this is done, the variety of activities will not necessarily cause confusion and misunderstanding because their relationship will be clearly defined.

In reality a close relationship exists between medical and social service when viewed from the standpoint of treatment. The patient is the unit of interest for both physician and social worker. The physician, into whose care the patient is entrusted, gathers his data on the ward, in the laboratory or library.

These data are analyzed, interpreted and related to a general plan of treatment, the ultimate purpose of which is restoration of health. The wise physician includes in his plan the related social factors, consequently the social worker is requested to go into the community and gather facts relative to environmental conditions and social relationships, and to study those factors which are associated with the mental health of patients. In addition to these factors an attempt is made to determine the degree of the patient's social adaptability and to create conditions suitable for community life. These data are analyzed, interpreted and related to a general plan of treatment by the social worker who also aids in carrying out the plan. This merging of medical and social service is fundamentally important if the institution is to deal effectively with persons whose mental condition and community relations are often seriously complicated.

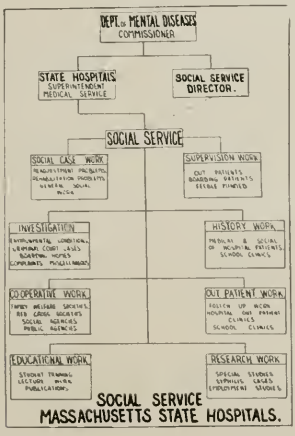
Misconduct and Mental Illness Interrelated

The most effective social work with patients is noted in those instances in which the physician from the first builds into his treatment plan those elements which relate to the social well being of the patient as an individual. This is particularly important in those cases in which the outstanding

symptoms of mental disorder are closely associated with some form of social misconduct. The interrelation of mental disorder and social misbehavior makes it doubly imperative that studies be made relative to personality, home and industrial conditions and social relationships with a view to relating the same to the general plan of treatment. The institution which adopts such a policy usually possesses a social consciousness and recognizes its obligations and responsibilities not alone to patients and their relatives, but to community organizations and to the general public.

The Massachusetts Program

In Massachusetts, a program for the development of social service in state institutions is primarily founded upon the central underlying principles of hospital social work with the expectation that the activities of the various departments shall be consciously directed and related to the medical social care and treatment of mental patients. The accompanying diagram indicates the organization scheme and main divisions of work.



SOCIAL SERVICE
MASSACHUSETTS STATE HOSPITALS.

It will be noted in observing this chart that the work divides itself into two main divisions—

(a) Intensive and slight service work *directly* related to the treatment of patients.

(b) Community work, more or less *indirectly* associated with treatment work which is essentially of an educational nature.

Although the bulk of state hospital social work is at present done in the community, a need for inside hospital social service is becoming more apparent. It is thought that the development of this phase of the work will result in more intelligent and continuous service in selected cases which indicate a need of constructive social case work.

Human Element Not Fully Developed

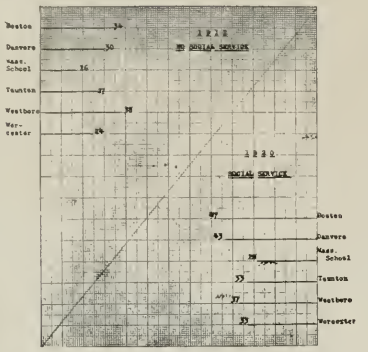
To the community the state hospital social service represents the human element of institution treatment and rightly so. It is very doubtful if this aspect of institution care has been duly and proportionately considered as compared with other departmental activities. The immediate relatives of patients and the public at large are apparently not so deeply concerned with the material development of state institutions or with scientific research as they are with measures which are directly related to the welfare of patients confined therein. Possibly one of the reasons why public financial support has not been more readily and cheerfully given is because the human element in hospital methods has not been sufficiently developed and emphasized to enlist lively public interest and cooperation. If then, the bond between hospital social service and the community is based largely upon the human interest element it fills a very great need; it does not, however, necessarily imply that such work is purely humanitarian for it relates itself directly to scientific and economic factors.

This interpretation of state hospital social work by the community has undoubtedly been largely instrumental in establishing the splendid degree of cooperation which is being realized in many communities, not alone in the contribution of information so necessary in the care of patients in the hospital, but in the assistance which is given in the community supervision and care of outpatients.

Patients Cured as Social Service Develops

Coincident with the advent of social service in state institutions, an increased number of outgoing patients have been noted. Modern methods of psychiatric treatment have doubtless been instrumental in this development, which is noted in various parts of the country since the way opened up whereby hospital extension work might be accomplished through social service. In order to determine more accurately the expansion of this phase of social work, a study was recently made of six Massachusetts institutions relative to outgoing patients. Two periods were chosen, 1912, the year prior to the advent of social service in state hospitals and 1920, when each of the six institutions had at least one social worker. The functions and population of these hospitals were practically the same for both periods. Increases in the number of outgoing patients were noted in all institutions with one exception, which may be accounted for on the ground that this hospital was in 1920 undergoing a process of reorganization.

The accompanying chart illustrates the foregoing statement:



The progress of any department of hospital organization probably depends, to a great extent, upon its actual value to all concerned, especially to patients. Considering social work from the standpoint of values, one discovers it to be of a threefold nature: (a) therapeutic; (b) economic; (c) educational.

From the therapeutic viewpoint we note: (1) patients who are able to appreciate the fact of out-patient social service and its various aspects must receive considerable relief from worry or anxiety over home and financial affairs which are often seriously affected by hospital commitment; (2) the modification or removal of conditions which have been contributing factors to mental breakdown may, in many instances, prevent or retard a recurrence of mental illness; (3) in the community out-patients are connected, when necessary, with medical resources; and (4) moral support is not infrequently given to patients by social workers.

In measuring the economic value of social work to the institution, it is hardly necessary to state that the value of a human being cannot be financially determined However, when any group of persons is under consideration for care at public expense, the financial cost of such care always becomes a very important factor and must therefore be considered in connection with this division of hospital activity.

In considering the great economic waste which naturally results upon the confinement of persons within an institution, it is important to devise means, when expedient, whereby such persons may in due course of time be restored to a degree of economic efficiency. The economic value of a department which attempts to do work of this kind, even in a small way, is obviously worthy of consideration. In many cases patients are industrially restored and readjusted, or partially so. Every patient released from the hospital and thus assisted becomes a contributor to the commonwealth of society and is a direct saving to the state in hospital maintenance. The possibility of releasing greater numbers of patients under adequate supervision will depend largely upon the development of well equipped social service departments in our institutions.

The educational value of psychiatric social work may be noted (a) in the instruction and guidance which are given to patients and relatives in regard to social factors pertaining to mental hygiene and social adaptiveness; (b) in the enlightenment to community agencies and industries relative to the peculiar needs of mental patients; (c) in the contribution of social data to hospital physicians which may be used in treatment or research work. Better knowledge of mental diseases will depend largely upon social investigation and observation in the community which are functions of the social worker.

Some Results of the Work Enumerated

The actual results of almost any kind of work connected with individuals must be largely conjectural. There are, however, certain obvious results of social service concerning which there can be but little difference of opinion. Through the investigation and case work of this department, actual facts in regard to the cases of patients are secured which frequently have a direct bearing upon diagnostic and treatment work; especially is this valuable in questions of discharge or parole visits.

The confidence of the community in the hospital care of out-patients is being established to the extent that patients are now much more readily received and more humanely treated, although much remains to be done in this field. It is becoming much easier to place patients in industry under supervision.

Definite information relative to hospital methods and treatment of mental disorders, when given at first hand to citizens outside an institution, results in modifying the stigma which for centuries has been attached to mental patients and to institutions erected for their care.

Definite policies which are established with community agencies through social service increase the possibilities for improved and more extensive community service.

The future development and progress of state hospital social work may be said to depend mainly upon three important factors:

(1) An enlightened public opinion through actual service and educational methods.

(2) The sincere and active interest and cooperation of those who are actually engaged in the care, treatment and prevention of mental diseases and allied ailments.

(3) The securing of a body of well trained, properly qualified social workers whose chief interest lies not in the development of social work as a profession but in the actual welfare of human beings, who because of mental or character ailments are socially incapacitated unless proper treatment can be administered.

GUIDE TO HOSPITAL SOCIAL SERVICE

Mercy Hospital at Pittsburgh has published an informative little four-page pamphlet entitled "Use the Social Service Department" which serves to introduce the public to the purposes of such work. It is divided into three parts: whom the social service department serves, when to use it and how to use it.

Because of the conciseness of its presentation the contents of the pamphlet are reprinted here as a suggestion to other institutions in developing their social service departments:

Social Service Department Aims to Be of Service

To Patients

By securing adequate medical care for those who need it.

By helping to restore them to normal life—normal physically, mentally, and morally—as quickly as possible.

By directing them to other agencies when there is some problem other than a medical problem involved.

By remedying the social maladjustments that cause and prolong illness, such as poverty, bad housing, poor sanitation, sufficient food or improper diet, immoral surroundings.

To Physicians and Nurses

By assisting in diagnosis through giving information regarding patient's home conditions and family history when such information cannot be obtained by a hospital interview.

By assisting in treatment through removing from home conditions any possible hindrances to recovery.

By visiting the patient after discharge so that an early recurrence of illness will be prevented, and arranging for convalescent care when necessary.

By seeing that patient follows out the advice given.

To The Management

By keeping the management in touch with the work and development of public and private health organizations.

By interpreting for it the problems of society which are of vital concern to the hospital in its work.

By showing the need and value of the extension of dispensary facilities.

To The Community

By carrying into the homes of the community the educational influences of the hospital.

By helping to check the spread of disease by seeking out those in need of treatment.

By reducing poverty through the reduction of illness.

By bringing to light, social and economic causes underlying physical disabilities.

When to Use the Social Service Department

In General

In any instance where there appears to be a deviation from the normal standard of living; for example: where there seems to be lack of proper food, clothing or shelter, insufficient income, immoral living conditions.

If the patient says he cannot accept the medical treatment advised because of children or other dependents, the social service department will endeavor to arrange for their care during treatment.

In The Hospital

If hospital care can be of no further service to patient, other accommodations may be secured so as to give room to a curable patient.

If patient is ready for discharge but needs a few weeks' rest in the country before going home, convalescent care may be arranged.

If patient has no place, or no desirable place, to go upon discharge.

If patient needs an interpreter.

If patient needs legal advice.

If patient is a deserted or unmarried mother and has no relatives that are likely to care for her upon discharge, or if her legal rights have not been looked after.

If patient needs treatment after discharge.

If patient is handicapped and needs employment fitted to his handicapped condition.

If patient should be in a home for the aged or in a hospital for the insane.

If patient desires or needs reading material.

In The Dispensary

In any instance where the examining physician recognizes the possible existence of a hindrance to recovery at home.

If patient cannot or will not take the treatment or advice or appliances recommended.

If patient has a communicable disease.

If patient has a communicable disease and other members of the family have not been examined.

If patient has a communicable disease and is to report regularly for treatment.

If patient is an expectant mother.

How to Use the Social Service Department

The aims of the department can be accomplished only through the closest cooperation and watchfulness on the part of everyone who comes in contact with the sick. Everyone associated with the hospital is essentially a part of the social service department.

The service of the department is not confined to non-paying patients.

The department believes in securing payment for medical service in every instance where payment is possible, and in asking for free medical service for only truly needy cases.

It is not within the scope of the work of the department to make direct financial investigations; however, if the financial circumstances of a patient are known to the department, such information will be given when requested.

We are all travelers in what John Bunyan calls the wilderness of this world * * * and the best that we find in our travels is an honest friend. He is a fortunate voyager who finds many. We travel indeed, to find them. They are the end of the reward of life. They keep us worthy of ourselves; and when we are alone, we are only nearer to the absent.—R. L. Stevenson.

The MODERN HOSPITAL

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SUPERINTENDENTS MAY PLAY PART IN ARCHITECTURAL CONTEST

MANY superintendents of small hospitals are working in buildings that are ill adapted to the institution's purpose. The laboratory is poorly located, the diet kitchens are too small, there are too few closets, the store room is difficult to get at. How often have we heard these superintendents express the wish that they might have an opportunity to cooperate with an architect in the planning of an efficient small hospital!

Such an opportunity is now offered them through THE MODERN HOSPITAL architectural competition for the plans of small hospitals. Indeed at the recent convention of the American Hospital Association several superintendents of small institutions expressed the intention of sketching their ideas of a thirty or forty bed hospital and getting their local architects to cooperate with them in drawing plans to conform to the provisions of the magazine's program.

To know that a goodly number of superintendents of small hospitals were cooperating with architects in the preparation of plans for submission in this contest would be gratifying. Superintendents undoubtedly have a valuable contribution to make in the planning of the small hospital. They know its requirements as do few architects who have not specialized in the planning of institutions of this character. In the interests of the better planning of small hospitals superintendents would do well to act on this suggestion.

PROLAPSIS SENSI HUMORI

THERE is a disease, not necessarily fatal but extremely prevalent, which exerts an extremely untoward influence on official efficiency. It may be congenital or acquired; it may be incurable but if recognized and subjected to careful treatment, it may be greatly ameliorated. Frequently it is easily cured. Sometimes the therapeutic measures must cover a considerable time, but no case should be classed as hopeless unless it is desired to consign the patient to chronic mediocrity. It is the one disease in which the patient may act as his own physician with impunity, in fact self treatment is absolutely essential to relief.

The disease exists in two forms. The first and more serious, known as ahumori, (don't look in the dictionary—the word is new) is a congenital absence of the sense of humor. This may be hereditary but may be cured if treated early. The second, or prolapsus sensi humori, is largely acquired. This is a temporary falling or lowering

of the sense of humor—at first an acute affection but prone to continue chronically. Either of these diseased states may be recognized by an observant layman; unfortunately the victim seldom makes the diagnosis and may even refuse to accept it at the hands of some well-meaning and therefore irritating friend.

In order that the discussion of the pathological condition may be approached logically, it is necessary to consider first of all the normal state in which the sense of humor has reached a proper degree of development. The sense of humor may be defined as that mental quality of detachment of the ego which permits one to stand aside and view impersonally the acts of one's self or other persons, and, having viewed them, to arrive at an impartial appraisement thereof. It is a thing apart from the sense of the obviously funny, yet the qualities of wit and fun enter into it. Fun carries with it the idea of playful action or speech. Wit is more purely intellectual and implies swift perception of the incongruous. Humor implies broader human sympathies, a more kindly sense of the incongruous often blended with pathos. The derivation of the word humor from the old Latin, meaning to be moist, conveys the idea that humor is the opposite of the dry and pessimistic. Thus it partakes of the sense of the ludicrous, yet in a kindly way, since it recognizes the partnership of the ridiculous in almost every human act. It is the antithesis of selfishness and its twin brothers, self-conceit and sham. It is a blessing to its possessor, a heartener when trouble comes and a chastener in the hour of success.

The concentration of official life seems to furnish the ideal for the fall of the sense of humor. One's job looks so big that everybody else's job seems to dwindle by comparison. One's work becomes a sacred thing to be protected against the inroads of all persons. Every little precedent of that job becomes a part of holy ritual and the very suggestions of change take on the aspect of the sacrilegious. The result is a drying up of the humor of human understanding and with the evaporation of this blessed fluid, there occurs a loss in mental volume, a narrowing of the perspective and a complete solidification of the fount of charity.

The acts of those about us take on a meaning which is absolutely foreign to their real intention. Opportunity knocks in vain at the door of a mind whose ears are deaf to all outside stimuli. Chronic mediocrity and the dull treadmill round of life continue until the kindly hand of time translates the unfortunate victim to the place where every one has a sense of humor. If heaven were otherwise, it would not be heaven.

The cure for this condition is found in not taking it to heart. We should realize that the work is going to go on a long time after we are dead; that if we do our work well now, the end results will take care of themselves in the future. Above all, let us not take ourselves or other people too seriously.

TO BUILD INSTITUTIONS BY BONDS

THE state of New Jersey not long ago attempted to raise money by a bond issue with which to rehabilitate and enlarge its charitable, penal and correctional institutions and to provide five additional ones.

Sixteen million dollars was asked. An extensive and thorough campaign was made by the state department of institutions. The governor of the state endorsed the issue. Friends of the helpless and unfortunate made appeals to the voters for support. Evidence was submitted showing graphically the need for the money. It was thoroughly explained that the existing institutions are far too small to accommodate those actually present within their walls, that there are many outside waiting for vacancies and that the state is not performing its full duty by the many who should be cared for in institutions.

The issue was safeguarded so that no additions could be made to taxes on its account. This was accomplished by providing that the annual interest and sinking fund obligations should have the first call upon the state's funds. The general assembly, according to the plan, should each year make an appropriation of funds sufficient to cover interest and sinking fund for these bonds. These two items should be included in the state budget, which is limited. Whatever was left unappropriated would be available for the other expenses of the state. This scheme admirably prevented any increase in taxes through a bond issue for this purpose.

Voters, however, did not take to the idea and the issue was defeated.

Those who supported it are confident that the campaign opened the eyes of the public to the inadequacy of the institutions in that state and to the failure of the state to make provision for types which are now recognized as proper subjects for institutionalization.

The public charitable, penal and correctional institutions all through the country have sunken into physical deterioration, are so far behind the times in economical and modern equipment and are so far short of capacity to meet the demands upon them, that the prevailing system of small annual doles by the general assembly

scarcely keeps them above the surface. Heroic means, such as the proposed New Jersey bond issue, are required to rescue these institutions and to establish them where they can perform for the state the service that it needs for its own protection and welfare.

NOMINATIONS FROM THE FLOOR

ONE of the outstanding features of the recent conference of the American Hospital Association at Atlantic City was the advantage taken of the recent constitutional amendment making it allowable to nominate officers from the floor and to elect by ballot.

There has existed in the association for many years a feeling that the selection of officers should not be left altogether in the hands of the nominating committee, and this meeting offered the first opportunity for the convention as a whole to express its wishes in the selection of officers for the ensuing year; this it did.

Arising from the satisfaction that came out of this procedure there is little doubt but that a high impartiality and devotion to the general interest of the association will result.

APPROVED HOSPITAL LIST GROWS

THE list of approved hospitals published last year by the American College of Surgeons contains the names of 564 or 74 per cent of the 761 general hospitals of 100 or more beds then existing in the United States and Canada. This represented an addition to the list of 176 hospitals during the year, but left 197 hospitals of 100 beds or more unapproved. We expressed the hope at that time that the 1922 list of the College would contain 90 per cent or more of the hospitals of 100 beds or more. As a matter of fact the 1922 list, which was made public at the Clinical Congress held at Boston on October 23-27, 1922, shows that 83 per cent of the 812 general hospitals of 100 beds in existence during 1922 are on the list.

Although the list as originally announced at the 1921 Clinical Congress contained 564 general hospitals, the number grew to 579 or 76 per cent of the total. Up to the time of the Clinical Congress the gain for this year, therefore, in terms of hospitals of one hundred beds or more is 98, in terms of percentage, seven. To this year's list, however, have been added 355 hospitals having a capacity of between fifty and 100 beds. This number represents 41 per cent of the 811 general hospitals of this size listed by the College. Taking the aggregate list of 1623 hospitals having 50 or more beds, 1012 or 62 per cent are meeting the minimum standards of the College. In view of the greater difficulties the smaller hospitals have in establishing the minimum standard they make an excellent showing in this first published list of approved hospitals of 50 to 100 beds and, as the College's reports indicate, are to be especially commended.

The publication of each successive list of the College gives increasing evidence of the desire of hospitals to give their patients the best service that modern medicine and modern hospital organization afford.

OVERCROWDING IN STATE HOSPITALS

ILLINOIS reports a net increase of 900 patients in its state hospitals during the year 1921. This is the greatest annual net increase on record in that state.

The American Legion and other organizations of soldiers of the recent World War complain to President Harding and to the Veterans' Bureau of the crowding of soldier patients in state hospitals.

Crowding has been a chronic condition for a long time in these institutions. The charge cannot be denied. Patients have been packed into state hospitals in every state until a situation has developed which is positively indecent and inhumane. No state that respects the truth has denied that its hospitals for nervous and mental cases have been crowded beyond reason. Doubtless other states have experienced increases in their hospital population comparable with that in Illinois in 1921. Institutions already overcrowded for years are now confronted with an unprecedented influx of patients, and the humiliating situation is to be aggravated since little provision has been made in the way of new wards to accommodate this gain in population.

New Jersey recently tried to put over a bond issue of $14,000,000 with which to rehabilitate and enlarge its state charitable and penal institutions, but the plan was defeated at the polls. Legislatures, confronted with desperate demands for money from numerous sources, overlook the insane and feeble-minded because there are few to speak for them. Their plight does not make the sound that hard roads and a dozen other subjects create when the whole populace unites to ask for them because they contribute to general comfort, convenience and prosperity.

Bishop Berkeley long ago suggested that, apart from the percipient mind, matter had no existence. Modern science stretches out a hand to him across the centuries, and agrees that matter may be nothing more than a condition of motion affecting our senses.—Robert W. Mackenna.

SMALL HOSPITAL ARCHITECTURAL CONTEST AWAKENS INTERNATIONAL INTEREST

DESIGNED to arouse the small community of the United States and Canada to its need of hospital facilities and to provide it with plans of a structure efficient in arrangement and inspiring in architecture, THE MODERN HOSPITAL'S $1,000 competition already has exceeded the imagined limits of its originators and the boundaries of a continent.

Within little more than the minimum time for the postal delivery between Chicago and London carrying the announcement of this magazine's plan of conducting an architectural contest on small hospital plans, there were received from the British capital three inquiries for details of the competition, a request for programs from the Royal Institute of British Architects and the registration of Architect Win Kidd of Chelsea, London. Other requests have followed in rapid succession.

Enthusiasm over the competition displayed by a New Zealand architect in a personal call at the Chicago office of THE MODERN HOSPITAL led to the dispatch, at his suggestion, of contest programs to the New Zealand Institute of Architects at Wellington. Publicity given the project in several French and German architectural journals has developed some interest in these countries.

Through such a succession of inquiries, THE MODERN HOSPTAL awoke to a realization of the international character of its competition. Since the contest was made open to all architects, contributions from foreign architects will be accepted.

UNTIL DECEMBER 15 TO REGISTER

Architects who desire to enter the $1,000 prize competition being conducted by THE MODERN HOSPITAL *for plans of a community hospital of 30 to 40 beds will be given until December 15 to register. The final date of registration has been set forward an entire month with a consequent advance of the date for submitting designs to February 1, 1923.*

Registrations, inquiries, and calls for the contest program from England, several European countries, and even New Zealand, have necessitated an extension of the registration limit. Foreign interest in the competition was entirely unanticipated by THE MODERN HOSPITAL, *owing to the vastly different conditions governing hospital construction abroad, but the contest is open to all architects and any such designs will not be excluded.*

Requests for complete programs of the competition have been reaching the Chicago office of the magazine at the rate of thirty a day, from architects not included among the original 1,800 to whom programs were mailed early in October. In the first fortnight following the announcement of the competition at the American Hospital Association conference at Atlantic City, twenty persons registered their intention of submitting designs.

To accommodate foreign competitors, the registration date for the contest, originally set for November 15 has been advanced one month. American architects also will be allowed to register their intention of entry up until December 15. This change of program has necessitated a change in the final date for submitting designs which under the revised plan becomes February 1. Communications in regard to the competition or the program will be received by the architectural adviser, Mr. Richard E. Schmidt of Chicago, up until January 1. Any information sought must be by anonymous letter, and a copy of such a letter and the answer to it will be sent simultaneously to each competitor.

In the United States and Canada interest in the competition has been instantaneous and widespread. Requests for programs have poured in from most of the Canadian provinces. The various sections of the country are surprisingly well represented among registrants. Only architects of the northwest have lingered over their registration, but from inquiries and requests for programs it is anticipated that several from that section will be entered before the deadline for registration is reached.

New York, New Jersey, District of Columbia, Tennessee, South Carolina, Georgia, Kentucky, Arizona, California, Minnesota, Indiana and Illinois, all have one or several architects competing.

Architectural Adviser Richard E. Schmidt of the firm, Richard E. Schmidt, Garden & Martin of Chicago, has put a liberal interpretation on the

word "architect" as employed in the general program of the contest and will accept the registrations of draftsmen in the offices of architectural firms. Post-graduate and even advanced students in colleges of architecture also will be allowed to submit designs and colleges will of course be eligible and it is hoped that several of them will try for the prizes.

Inspired by the example of several superintendents, who at the American Hospital Association convention in Atlantic City expressed their intention of cooperating with their local architects in submitting designs, other hospital administrators have set about plotting their dream of a modern small hospital or a remodelled present structure and will turn their suggestions over to their local architect for elaboration.

An interesting phase of the competition thus far is that heads of several well known firms in hospital architecture are competing with draftsmen from their own offices.

A jury of award, its personnel to include two architects of recognized standing, two seasoned hospital superintendents, and one registered nurse who has had experience in small hospital administration, will be announced in the December issue.

Throughout the period of the contest will be published a series of articles on small hospital construction. In this issue are described the Egeland Hospital, a private institution at Sturgeon Bay, Wis., and the Grinnell Community Hospital, an actively functioning health center at Grinnell, Iowa.

MORE THAN 1,000 HOSPITALS OF FIFTY OR MORE BEDS MEET MINIMUM STANDARD OF A. C. S.*

A HIGH ideal of hospital service, a vision of community responsibility, a method by which this responsibility can be met efficently day by day—this is Hospital Standardization. The following pages contain a report for 1922 of the progress of this movement—that of giving to the public the best service known to the science of medicine. It stands as a tribute to the idealism and the service of the combined medical and hospital professions.

Soon after its organization, the American College of Surgeons felt the urgent need of improving hospital records, as applicants for admission to the College were required to submit as a part of their examination one hundred case records of major operations. These records were so incomplete and fragmentary in many instances that the College became thoroughly convinced of the necessity for a widespread campaign to improve them. This was the initial germ causing the hospital standardization movement; as it developed, other factors in hospital betterment presented themselves, such as the need for more adequate laboratory service and more efficient staff organization.

The Hospital Staff

The first consideration in the minimum standard, as evolved by the American College of Surgeons in 1919, is the hospital staff. It is unfortunately true that organization in hospital effort has not advanced to a degree comparable with its development in other technical lines. Surely there is no excuse for the human repair shop—the hospital—to fall behind in organization, always all important in promoting the highest efficiency. Responsibility for the various activities of the hospital must be centered in certain committees or individuals. The program for the staff meetings, the case records, the laboratory service, the nursing care, and the intern service, are but a few of the important activities, the responsibility for which should be centralized.

The goal of the organized staff, and indeed the aim of the standardization program, is the analysis of the hospital's results. As expressed by Mr. John G. Bowman, "The staff meeting is the pivot upon which the success or failure of hospital standardization turns." It is the medium, through which this entire campaign finds expression. Without it, a hospital's efforts to a large degree fail.

The staff conference, perhaps more than any other factor, has improved the tone of hospital service during the past few years. It is the feeling of the College that these meetings should be devoted largely to a discussion of the so-called casualties, including deaths, infections, complications, and unimproved cases.

Laboratories

One of the great advances in modern medicine has been in the direction of laboratory aid in diagnosis. Indeed, this constitutes one of the greatest distinctions between the practice of medicine today and that of our forefathers. Hospitals owe their patients the benefits of this advance in medical science. The laboratory in no sense, however, should be considered as a shortcut to diagnosis, supplanting the careful taking of a history and a painstaking physical examination. Combined with the latter, however, it furnishes an invaluable means of assistance, often making clear an otherwise obscure diagnosis.

The necessity, then, for making careful arrangements for adequate laboratory service, needs no argument. As a minimum, hospitals should have facilities for the examination of urine, blood, exudates, bacteriological slides, and for the growth of cultures. It may be impractical, however, for some hospitals to have equipment for the more technical examinations, such as serological and histological tests. Arrangements must be made with a reliable laboratory for accurate and prompt service for these more detailed examinations.

Even in hospitals with complete laboratory facilities, one frequently finds laboratory service markedly deficient, due to the insufficient quantity of tests performed, especially for private patients. This is due largely to two

*Extracts from the report for 1922 of the American College of Surgeons on Hospital Standardization, together with a complete list of 1,102 general hospitals of fifty or more beds in the United States and Canada which meet the minimum standard of the College.

causes: first, the system of charging an individual fee for each test performed; and second, to the apathy of many staff members toward the laboratory. It cannot be too strongly emphasized that almost without exception, hospitals which charge individual fees for their laboratory tests, perform a relatively small number of tests per patient. Under such conditions, naturally, the hospital cannot assume a definite routine of laboratory service, as an immediate objection to the cost would be raised. The only solution apparent at the present time is the adoption of a flat-rate fee. This allows the hospital, and rightly, to assume the responsibility of having each patient receive adequate laboratory aid. The uniform success of this plan has been proved in so many instances, that it can be accepted as an established fact.

The x-ray department in the hospital should have a qualified roentgenologist in charge, if only in a part-time, supervisory capacity. Patients, in general, do not receive uniformly competent service if interpretations are relegated to individual physicians.

The College makes no specific recommendations concerning the number of routine laboratory examinations to be employed by hospitals. A routine urinalysis, of course, is performed in the majority of hospitals. Many perform a routine hæmoglobin determination and leucocyte count also—a practice to be strongly recommended. Some hospitals have a routine Wassermann test in certain wards or services. Fortunately, the practice of having a routine examination of every tissue removed in the operating room is becoming quite prevalent. This is a factor of paramount importance. Every specimen from the operating room should be sent to the laboratory automatically; this should be as rigid a part of the operating room technique as the sterilization of instruments. Every specimen should be examined by the pathologist, who submits at least a gross report of his examination and has a histological examination made whenever possible. Data of tremendous scientific value are becoming available due to the practice of sectioning practically all specimens from the operating room. Furthermore, this practice gives the hospital an insight into its operating room service that can be obtained in no other way.

Case Records

The absolute and fundamental importance of case records is a commonly acknowledged fact and needs no argument here. A careful study of the history of a patient's illness and a painstaking physical examination are procedures of such great importance that their value must be preserved. Failure to record these data constitutes a tremendous economic loss and waste, to say nothing of the future bearing on the welfare and lives of the patients. How then, can the possession of a complete record system be facilitated? Its accomplishment requires the mutual cooperation of the hospital and its staff members.

The duties of the hospital in this connection consist, first of all, in supplying adequate personnel to secure the records. In the absence of interns, record clerks are essential. Even the small hospital is entitled to a full-time historian, although it is quite common for these historians to devote part of their time to other activities of the hospital. An efficient record committee is another necessary adjunct to the historian's work.

Many hospitals fail to provide adequate space for the record department. For this purpose a room large enough to contain the records of many years should be set aside, adjacent to the hospital office. All plans for new hospitals should bear this important feature in mind. This department should contain standard filing cabinets and card indices for names and diseases; for each record must be immediately accessible.

Personal study in over 1,600 hospitals during the past four years has shown a progressive improvement in the records. Certain prevalent shortcomings, however, are worthy of special emphasis. Extreme brevity is a common fault, coupled with a tendency to dismiss important regions of the body from consideration by too promiscuous use of the words "normal," or "negative." A tendency to a stereotyped form of history and physical examination record is encountered frequently. Such charts have little individuality or clinical value and result from two causes: failure to record the data until shortly before or after the patient's discharge; and from lack of supervision of the records by the hospital staff.

The importance of having the working diagnosis recorded early is insufficiently realized. This, in itself, will correct many existing difficulties in connection with other phases of the records. Operation records are almost universally weak in describing the exploratory findings and operative technique. The solution for this seems to be the dictation of these data during or immediately following each operation.

Method and Results of the Surveys

The hospital surveys of the College are *personal* surveys. Experience has shown that a study of hospital conditions through the correspondence and questionnaires leads to many inaccuracies. The College surveys are conducted through a trained corps of hospital visitors, all of whom are graduates in medicine. The number of visitors employed in any year has never exceeded ten. Since the uniformity of a survey varies in inverse proportion with the number of men employed, by using relatively few visitors, all similarly trained, the College obtains strictly uniform reports. As an additional safeguard, each visitor covers a large number of states and provinces in order that he may obtain a general, rather than a local, viewpoint of hospital conditions. This uniformity in the reports is an absolute essential to a just rating of hospitals. Upon such detailed personal surveys, the College is dependent for an accurate estimate of each hospital's status relative to the minimum standard.

The purpose of the visitors is to explain the minimum standard, to interpret its application to each hospital, and to offer constructive criticism and helpful suggestions to remedy any existing shortcomings. This campaign is one of suggestion only; there is no element of coercion entailed. It succeeds through the sanction and approval of the hospitals themselves.

Other organizations interested in hospital betterment have played a prominent rôle in advancing hospital standardization. The program of the College has been enhanced greatly by the endorsement of such organizations as the American Hospital Association, the American Conference on Hospital Service, the Canadian Medical Association, the Catholic Hospital Association, the Conference Board of Hospitals and Homes of the Methodist Church, the Medical and Surgical Section of the American Railway Association, the Methodist Hospital Association, the Protestant Hospital Association, and numerous state, provincial, and local organizations.

Interns and nurses are using the approved list of the College as a guide in the selection of institutions in which to pursue their training. The public is making increasing use of it as a means of determining which institu-

tions offer safe and competent hospital care. Benevolent foundations employ it in deciding upon hospitals which are worthy of financial aid. The American Railway Association has recommended that all railroad employes, wherever possible, be treated in hospitals meeting the minimum standard. The United States Government, in its selection of hospitals for the treatment of its disabled veterans, utilizes the information furnished through the surveys and approved lists of the College.

Four annual surveys of the general hospitals in the United States and Canada have been made. Of the institutions having one hundred or more beds, 89 were found to meet the standard in 1918; in 1919, 198 fulfilled the requirements; in 1920, 407 or 57 per cent met the standard; in 1921 the number of approved hospitals grew to 579 or 76 per cent; and this year 677 or 83 per cent of the 812 hundred bed general hospitals are on the approved list.

Of the 811 general hospitals having a capacity of between fifty and one hundred beds, 335 or 41 per cent are approved, an excellent showing in view of the fact that previous lists published by the College have not included these smaller institutions.

Grouping together the 1,623 general hospitals having fifty or more beds, there are 1,012 or 62 per cent meeting the requirements of the standard.

The Fifty Bed Hospitals

Although the College has been surveying the smaller hospitals since 1920, it was deemed advisable to withhold their publication on the approved list until sufficient time had elapsed to give them an opportunity to familiarize themselves thoroughly with the standardization program.

The smaller hospitals are under greater difficulties than the larger institutions. Many are forced to be practically self-supporting; the physicians are more prone to develop personal rivalries which retard staff organization; it is difficult for them to obtain interns; and sufficient laboratory service is often a serious problem. In spite of these difficulties, however, the small hospitals have welcomed the minimum standard with the same spirit manifested by the large institutions. Indeed, it is in these small hospitals that the greatest change in hospital service has been manifested. It requires patience to establish a complete case record system; to organize a harmoniously functioning staff; and to arrange for adequate laboratory service. These small institutions are to be especially commended, therefore, on the excellent showing which they have made.

Hospital Standardization

In the United States and Canada there are 811 general hospitals having between fifty and one hundred beds. Of these, 335 or 41 per cent are on the approved list. This exceeds the percentage of hundred bed hospitals which met with approval at the time of the first survey.

The surveys of the College have demonstrated that the hospitals of this continent are receptive to any means of improving their service to the public. As the sphere of hospitals has widened, so have their responsibilities increased. Sensing these ever deepening responsibilities and obligations, hospitals looked forward to a means of satisfying their broadened conception and ideals of community service. The minimum standard and the standardization program of the College furnished a concrete method by which these aspirations could be reached. The future will see the further elaboration by hospitals of the principles of the minimum standard, and a fuller realization of the spirit embodied therein.

LIST OF APPROVED HOSPITALS[1]

Capacity of 50 Beds and Over

The following list contains the names of those general hospitals of fifty or more beds, in the United States and Canada, which meet the minimum standard. In this list a certain number of the institutions are designated with an asterisk. This group includes those hospitals which, when visited, had adopted the fundamental principles of the minimum standard, but which at that time had not developed all of them to a degree meriting the fullest approval. The hospitals listed without an asterisk have received the benefits of a longer experience in the workings of the program and consequently a broader conception of its application.

UNITED STATES

ALABAMA

100 or more beds

*Birmingham Baptist Hospital, Birmingham
Employes Hospital, T. C. I. & R. R. Co., Birmingham.
Hillman Hospital, Birmingham
Mobile City Hospital, Mobile
*Norwood Hospital, Birmingham
*Providence Infirmary, Mobile
*St. Vincent's Hospital, Birmingham
South Highlands Infirmary, Birmingham

50 to 100 beds

*Alabama Baptist Hospital, Selma
*John A. Andrew Memorial Hospital, Tuskegee
Vaughan Memorial Hospital, Selma

ARIZONA

100 or more beds

*St. Joseph's Hospital, Phoenix

ARKANSAS

100 or more beds

Logan H. Roots Memorial Hospital, Little Rock
St. Louis Southwestern Hospital, Texarkana
St. Vincent's Hospital, Little Rock
*Sparks Memorial Hospital, Fort Smith

50 to 100 beds

Baptist State Hospital, Little Rock
*Leo N. Levi Memorial Hospital, Hot Springs
Michael Meagher Memorial Hospital, Texarkana
St. Bernard's Hospital, Jonesboro
St. Luke's Hospital and Annex, Little Rock

CALIFORNIA

100 or more beds

Alameda County Hospital, San Leandro
Children's Hospital, Los Angeles
Children's Hospital, San Francisco
*French Hospital, San Francisco
*Fresno County Hospital, Fresno
*Golden State Hospital, Los Angeles
Hospital for the Good Samaritan, Los Angeles
Lane Hospital, San Francisco
*Loma Linda Sanitarium and Hospital, Loma Linda
Los Angeles County Hospital, Los Angeles
Mary's Help Hospital, San Francisco
Mt. Zion Hospital, San Francisco
*O'Connor Sanitarium, San Jose
Pasadena Hospital, Pasadena
Providence Hospital, Oakland
*Sacramento Hospital, Sacramento
St. Francis Hospital, San Francisco
St. Joseph's Hospital, San Diego
St. Joseph's Hospital, San Francisco
St. Mary's Hospital, San Francisco
St. Vincent's Hospital, Los Angeles
San Diego County Hospital, San Diego
San Francisco Hospital, San Francisco
*San Joaquin General Hospital, French Camp
Santa Barbara Cottage Hospital, Santa Barbara
Santa Clara County Hospital, San Jose
Santa Fe Coast Lines Hospital, Los Angeles
Southern Pacific Hospital, San Francisco
University of California Hospital, San Francisco
White Memorial Hospital, Los Angeles

50 to 100 beds

*Mercy Hospital, Bakersfield
*Murphy Memorial Hospital, Whittier
*Paradise Valley Sanitarium, National City
*Ramona Hospital, San Bernardino
*St. Francis Hospital, Santa Barbara

COLORADO

100 or more beds

Children's Hospital, Denver
Glockner Sanatorium, Colorado Springs
Mercy Hospital, Denver
Minnequa Hospital, Pueblo
St. Anthony's Hospital, Denver
St. Francis Hospital, Colorado Springs
*St. Joseph's Hospital, Denver
*St. Luke's Hospital, Denver
St. Mary's Hospital, Pueblo

[1]This list is complete only to October 6, 1922.

50 to 100 beds

*Denver and Rio Grande Western Railroad Hospital, Salida
*Red Cross Hospital, Salida

CONNECTICUT

100 or more beds

Bridgeport Hospital, Bridgeport
Grace Hospital, New Haven
Greenwich General Hospital, Greenwich
Hartford Hospital, Hartford
*Hospital of St. Raphael, New Haven
Lawrence and Memorial Associated Hospitals, New London
New Haven Hospital, New Haven
St. Francis Hospital, Hartford
St. Mary's Hospital, Waterbury
St. Vincent's Hospital, Bridgeport
*Stamford Hospital, Stamford
Waterbury Hospital, Waterbury

50 to 100 beds

New Britain General Hospital, New Britain

DELAWARE

100 or more beds

Delaware Hospital, Wilmington

50 to 100 beds

*Homeopathic Hospital, Wilmington

DISTRICT OF COLUMBIA

100 or more beds

Central Dispensary and Emergency Hospital, Washington
Children's Hospital, Washington
Columbia Hospital for Women, Washington
Freedman's Hospital, Washington
Garfield Memorial Hospital, Washington
George Washington University Hospital, Washington
Georgetown University Hospital, Washington
Providence Hospital, Washington
*Washington Sanitarium and Hospital, Washington.

FLORIDA

100 or more beds

*Duval County Hospital, Jacksonville
*St. Luke's Hospital, Jacksonville

50 to 100 beds

Gordon Keller Memorial Hospital, Tampa
*Miami City Hospital, Miami

GEORGIA

100 or more beds

*Davis-Fischer Sanatorium, Atlanta
Georgia Baptist Hospital, Atlanta
Grady Memorial Hospital, Atlanta
Harbin Hospital, Rome
Piedmont Sanatorium, Atlanta
*St. Joseph's Infirmary, Atlanta
University Hospital, Augusta

50 to 100 beds

*Athens General Hospital, Athens
*Downey Hospital, Gainesville
*Park View Sanitarium, Savannah
Scottish Rite Hospital, Decatur

IDAHO

100 or more beds

St. Alphonsus Hospital, Boise

50 to 100 beds

Pocatello General Hospital, Pocatello
*Providence Hospital, Wallace
St. Anthony's Hospital, Pocatello
*St. Luke's Hospital, Boise

ILLINOIS

100 or more beds

Alexian Brothers Hospital, Chicago
Augustana Hospital, Chicago
Chicago Lying-In Hospital, Chicago
Children's Memorial Hospital, Chicago
Columbus Hospital, Chicago
Cook County Hospital, Chicago
Evanston Hospital, Evanston
*Frances E. Willard Hospital, Chicago
Grant Hospital, Chicago
Hahnemann Hospital, Chicago
*Hinsdale Sanitarium, Hinsdale
*Hospital of St Anthony de Padua, Chicago
Illinois Central Hospital, Chicago
*Illinois Charitable Eye and Ear Infirmary, Chicago
*Lake View Hospital, Danville
Lutheran Deaconess Hospital, Chicago
Mercy Hospital, Chicago
Michael Reese Hospital, Chicago
Misericordia Hospital, Chicago
Mt. Sinai Hospital, Chicago
Presbyterian Hospital, Chicago
Rockford Hospital, Rockford
St. Anne's Hospital, Chicago
St. Bernard's Hospital, Chicago
*St. Elizabeth's Hospital, Chicago
*St. Elizabeth's Hospital, Danville
St. Francis Hospital, Blue Island
St. Francis Hospital, Evanston
St. Francis Hospital, Peoria
St. Joseph's Hospital, Chicago
*St. Joseph's Hospital, Joliet
St. Luke's Hospital, Chicago
*St. Mary's Hospital, East St. Louis
St. Mary's Hospital, LaSalle
*St. Mary's Infirmary, Cairo
St. Mary of Nazareth Hospital, Chicago
South Shore Hospital, Chicago
Swedish Covenant Hospital, Chicago
University Hospital, Chicago
*Washington Park Hospital, Chicago
Wesley Memorial Hospital, Chicago

50 to 100 beds

*Columbus Extension Hospital, Chicago
*Garfield Park Hospital, Chicago
Huber Memorial Hospital, Pana
Illinois Masonic Hospital, Chicago
*Lake View Hospital, Chicago
*Lutheran Hospital, Moline
North Chicago Hospital, Chicago
Olney Sanitarium, Olney
Our Saviour's Hospital, Jacksonville
Passavant Memorial Hospital, Jacksonville
*Post-Graduate Hospital, Chicago
*Provident Hospital, Chicago
St. Andrew's Hospital, Murphysboro
*St. Francis Hospital, Freeport
*South Side Hospital, Chicago
Washington Boulevard Hospital, Chicago

INDIANA

100 or more beds

Fort Wayne Lutheran Hospital, Fort Wayne
Gary Hospital, Gary
Indianapolis City Hosnital, Indianapolis
Methodist Episcopal Hospital, Indianapolis
Robert W. Long Hospital, Indianapolis
St. Anthony's Hospital, Terre Haute
St. Elizabeth's Hospital, LaFayette
St. Joseph's Hospital, Fort Wayne
St. Margaret's Hospital, Hammond
St. Mary's Hospital, Evansville
St. Mary's Mercy Hospital, Gary
St. Vincent's Hospital, Indianapolis

50 to 100 beds

Epworth Hospital, South Bend
*Holy Family Hospital, LaPorte
LaFayette Home and Hospital, LaFayette
Muncie Home Hospital, Muncie
*Protestant Deaconess Home and Hospital, Evansville
*Reid Memorial Hospital, Richmond
St. Joseph's Hospital, South Bend
*Union Hospital, Terre Haute
Walker Hospital, Evansville

IOWA

100 or more beds

Finley Hospital, Dubuque
Iowa Lutheran Hospital, Des Moines
Iowa Methodist Hosnital, Des Moines
Jennie Edmundson Hospital, Council Bluffs
Mercy Hospital, Cedar Rapids
Mercy Hospital, Council Bluffs
Mercy Hospital, Davenport
*Mercy Hospital, Des Moines
St. Francis Hospital, Waterloo
St. Joseph's Mercy Hospital, Dubuque
St. Joseph's Mercy Hospital, Sioux City
St. Vincent's Hospital, Sioux City
University Hospital, Iowa City

50 to 100 beds

*Iowa Congregational Hospital, Des Moines
*Iowa State College Hospital, Ames
*Lutheran Hospital, Sioux City
*Ottumwa Hospital, Ottumwa
Park Hospital, Mason City
St. Joseph's Mercy Hospital, Clinton
St. Joseph's Mercy Hospital, Fort Dodge
St. Joseph's Mercy Hospital, Mason City
*St. Joseph's Mercy Hospital, Waverly
*Samaritan Hospital, Sioux City

KANSAS

100 or more beds

Bethany Methodist Hospital, Kansas City
St. Francis Hospital, Wichita
St. Margaret's Hospital, Kansas City
*Wichita Hospital, Wichita

50 to 100 beds

Axtell Hospital, Newton
Bell Memorial Hospital, Kansas City
Halstead Hospital, Halstead
Hutchinson Methodist Hospital, Hutchinson
*Mercy Hospital, Fort Scott
*Mt. Carmel Hospital, Pittsburg
Providence Hosnital, Kansas City
*St. Elizabeth's Hospital, Hutchinson
St. Francis Hospital, Topeka
St. John's Hospital, Salina
*St. Joseph's Hospital, Concordia

KENTUCKY

100 or more beds

Good Samaritan Hosnital, Lexington
Louisville City Hospital, Louisville
Norton Memorial Hospital, Louisville
St. Anthony's Hospital, Louisville
*St. Elizabeth's Hospital, Covington
SS. Elizabeth and Mary Hospital, Louisville
St. Joseph's Hospital, Lexington
St. Joseph's Infirmary, Louisville

50 to 100 beds

*Booth Memorial Hospital, Covington
*Children's Free Hospital, Louisville
*Deaconess Hospital, Louisville
Illinois Central Hospital, Paducah
*Jewish Hospital, Louisville

LOUISIANA

100 or more beds

Charity Hosnital, New Orleans
Hotel Dieu, New Orleans
*Presbyterian Hospital, New Orleans
St. Francis Sanitarium, Monroe
T. E. Schumpert Memorial Hospital, Shreveport
Touro Infirmary, New Orleans

50 to 100 beds

*Illinois Central Railroad Hospital, New Orleans
*North Louisiana Sanitarium, Shreveport

MAINE

100 or more beds

Eastern Maine General Hospital, Bangor
*Maine General Hospital, Portland
*St. Mary's General Hospital, Lewiston

50 to 100 beds

*Children's Hospital, Portland

MARYLAND

100 or more beds

*Alleghany Hospital, Cumberland
Bay View City Hospital, Baltimore
Church Home and Infirmary, Baltimore
Franklin Square Hospital, Baltimore
Hebrew Hospital and Asylum, Baltimore
Hospital for Women of Maryland, Baltimore
Johns Hopkins Hospital, Baltimore
Maryland General Hospital, Baltimore
Mercy Hospital, Baltimore
Morrow Hospital, Baltimore
St. Agnes Hospital, Baltimore
St. Joseph's Hospital, Baltimore
Union Memorial Hospital, Baltimore
University Hospital, Baltimore

50 to 100 beds

Children's Hospital School, Baltimore
Emergency Hospital, Easton
Frederick City Hospital, Frederick
South Baltimore General Hospital, Baltimore

MASSACHUSETTS

100 or more beds

Beverly Hospital, Beverly
Boston City Hospital, Boston
Brockton Hospital, Brockton
*Burbank Hospital, Fitchburg
Cambridge City Hospital, Cambridge
Cambridge Hospital, Cambridge
Carney Hospital, Boston
Children's Hospital, Boston
City Hospital, Fall River
*Cooley-Dickinson Hospital, Northampton
Free Hospital for Women, Boston
Holyoke City Hospital, Holyoke
House of Mercy Hospital, Pittsfield
Lawrence General Hospital, Lawrence
Long Island Hospital, Boston
Lowell Corporation Hospital, Lowell
Lowell General Hospital, Lowell
Lynn Hospital, Lynn
*Malden Hospital, Malden
Massachusetts Charitable Eye and Ear Infirmary, Boston
Massachusetts General Hospital, Boston
Massachusetts Homeopathic Hospital, Boston
Memorial Hospital, Worcester
Mercy Hospital, Springfield
New England Hospital for Women and Children, Boston
Newton Hospital, Newton Lower Falls
*Noble Hospital, Westfield
Peter Bent Brigham Hospital, Boston
Providence Hospital, Holyoke
St. Elizabeth's Hospital, Boston
St. John's Hospital, Lowell
*St. Luke's Hospital, New Bedford
St. Vincent's Hospital, Worcester
Salem Hospital, Salem
Springfield Hospital, Springfield
Union Hospital, Fall River
*Waltham Hospital, Waltham
*Wesson Memorial Hospital, Springfield
Worcester City Hospital, Worcester

50 to 100 beds

Beth Israel Hospital, Boston
Boston Lying-in Hospital, Boston
Clinton Hospital, Clinton
Farren Memorial Hospital, Montague City
*Faulkner Hospital, Boston
*Hart Private Hospital, Brookline
House of the Good Samaritan, Boston
Infants' Hospital, Boston
North Adams Hospital, North Adams
*Quincy City Hospital, Quincy
Truesdale Hospital, Fall River

MICHIGAN

100 or more beds

Battle Creek Sanitarium, Battle Creek
Blodgett Memorial Hospital, Grand Rapids
Butterworth Hospital, Grand Rapids
Children's Free Hospital, Detroit
Detroit Receiving Hospital, Detroit
*Edward W. Sparrow Hospital, Lansing
*Evangelical Deaconess Hospital, Detroit
Grace Hospital, Detroit
Hackley Hospital, Muskegon
Harper Hospital, Detroit
Henry Ford Hospital, Detroit
Highland Park General Hospital, Highland Park
House of Providence, Detroit
*Hurley Hospital, Flint
Mercy Hospital, Bay City
*New Borgess Hospital, Kalamazoo
*Old Borgess Hospital, Kalamazoo
St. Joseph's Hospital, Ann Arbor
St. Mary's Hospital, Detroit
St. Mary's Hospital, Grand Rapids
University Hospital, Ann Arbor
W. A. Foote Memorial Hospital, Jackson
Woman's Hospital and Infants' Home, Detroit

50 to 100 beds

*Bronson Methodist Hospital, Kalamazoo
*Detroit Eye, Ear, Nose and Throat Hospital, Detroit
*Ishpeming Hospital, Ishpeming
Memorial Hospital, Owosso
Mercy Hospital, Jackson
*Nichols Memorial Hospital, Battle Creek
Saginaw General Hospital, Saginaw
St. Mary's Hospital, Saginaw
Samaritan Hospital, Detroit

MINNESOTA

100 or more beds

*Abbott Hospital, Minneapolis
Bethesda Hospital, St. Paul
*Charles T. Miller Hospital, St. Paul
City and County Hospital, St. Paul
Colonial Hospital, Rochester
Deaconess Hospital, Minneapolis
*Eitel Hospital, Minneapolis
Fairview Hospital, Minneapolis
Minneapolis General Hospital, Minneapolis
Minnesota State Hospital for Indigent Children, St. Paul
Mounds Park Sanitarium, St. Paul
Northern Pacific Beneficial Association Hospital, St. Paul
Northwestern Hospital, Minneapolis
St. Barnabas Hospital, Minneapolis
St. Joseph's Hospital, St. Paul
*St. Luke's Hospital, Duluth
*St. Luke's Hospital, St. Paul
St. Mary's Hospital, Duluth
St. Mary's Hospital, Minneapolis
St. Mary's Hospital, Rochester
St. Paul Hospital, St. Paul
Swedish Hospital, Minneapolis
University of Minnesota Hospital, Minneapolis
Worrell Hospital, Rochester

50 to 100 beds

Hill Crest Surgical Hospital, Minneapolis
*Immanuel Hospital, Mankato
*St. Gabriel's Hospital, Little Falls
St. John's Hospital, St. Paul
*St. Joseph's Hospital, Mankato
St. Raphael's Hospital, St. Cloud

MISSISSIPPI

100 or more beds

East Mississippi Charity Hospital, Meridian

MISSOURI

100 or more beds

Alexian Brothers Hospital, St. Louis
Barnes Hospital, St. Louis
Children's Hospital, Kansas City
Christian Church Hospital, Kansas City
*Evangelical Deaconess Home and Hospital, St. Louis
Frisco Employees Hospital, St. Louis
*Grace Hospital, Kansas City
Jewish Hospital, St. Louis
Kansas City General Hospital, Kansas City
Lutheran Hospital, St. Louis
Missouri Baptist Sanitarium, St. Louis
Missouri Pacific Railroad Hospital, St. Louis
Research Hospital, Kansas City
St. Anthony's Hospital, St. Louis
St. John's Hospital, St. Louis
St. Joseph's Hospital, Kansas City
St. Louis Children's Hospital, St. Louis
St. Louis City Hospital, St. Louis
St. Louis Mullanphy Hospital, St. Louis
St. Luke's Hospital, St. Louis
St. Mary's Hospital, Kansas City
St. Mary's Infirmary, St. Louis

50 to 100 beds

Bethesda Hospital, St. Louis
*Frisco Employees Hospital, Springfield
*Parker Memorial Hospital, Columbia
*St. Francis Hospital, Cape Girardeau
St. Francis Hospital, Maryville
St. John's Hospital, Joplin
St. Luke's Hospital, Kansas City
St. Mary's Hospital, Jefferson City
Trinity Lutheran Hospital, Kansas City
University Hospital, Kansas City

MONTANA

100 or more beds

Columbus Hospital, Great Falls
Montana Deaconess Hospital, Great Falls
Murray Hospital, Butte
St. James Hospital, Butte
*St. Patrick's Hospital, Missoula

50 to 100 beds

*Bozeman Deaconess Hospital, Bozeman
*Northern Pacific Beneficial Association Hospital, Missoula
*St. Ann's Hospital, Anaconda
*St. Joseph's Hospital, Lewistown
St. Vincent's Hospital, Billings

NEBRASKA

100 or more beds

Nebraska Methodist Episcopal Hospital, Omaha
St. Elizabeth's Hospital, Lincoln
St. Francis Hospital, Grand Island
St. Joseph's Hospital, Omaha
St. Mary's Hospital, Columbus
University of Nebraska Hospital, Omaha

50 to 100 beds

*Immanuel Deaconess Hospital, Omaha
Presbyterian Hospital, Omaha
*Swedish Mission Hospital, Omaha

NEVADA

50 to 100 beds

*Elko General Hospital, Elko

NEW HAMPSHIRE

100 or more beds

St. Joseph's Hospital, Nashua

50 to 100 beds

*Elliott Hospital, Manchester
*Hospital of Notre Dame, Manchester
Mary Hitchcock Memorial Hospital, Hanover
Nashua Memorial Hospital, Nashua

NEW JERSEY

100 or more beds

Alexian Brothers Hospital, Elizabeth
Atlantic City Hospital, Atlantic City
Bayonne Hospital and Dispensary, Bayonne
Christ Hospital, Jersey City
Cooper Hospital, Camden
Elizabeth General Hospital, Elizabetb
Englewood Hospital, Englewood
Hackensack Hospital, Hackensack
Jersey City Hospital, Jersey City
Mercer Hospital, Trenton
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Mountainside Hospital, Montclair
Muhlenberg Hospital, Plainfield
Newark Beth Israel Hospital, Newark
Newark City Hospital, Newark
Newark Memorial Hospital, Newark
*Newark Presbyterian Hospital, Newark
Orange Memorial Hospital, Orange
Passaic General Hospital, Passaic
Paterson General Hospital, Paterson
St. Elizabeth's Hospital, Elizabeth
St. Francis Hospital, Jersey City
St. Francis Hospital, Trenton
*St. Joseph's Hospital, Paterson
*St. Mary's Hospital, Hoboken
*St. Michael's Hospital, Newark
*St. Peter's General Hospital, New Brunswick

50 to 100 beds

Ann May Memorial Hospital, Spring Lake
*Homeopathic Hospital, Newark
*Hospital and Home for Crippled Children, Newark
*Hospital for Women and Children, Newark
*Middlesex General Hospital, New Brunswick
Nathan and Miriam Barnert Memorial Hospital, Paterson
*St. James Hospital, Newark

NEW YORK

100 or more beds

Albany Hospital, Albany
*Arnot-Ogden Memorial Hospital, Elmira
Bellevue Hospital, New York
Beth Israel Hospital, New York
Beth Moses Hospital, Brooklyn
*Binghamton City Hospital, Binghamton
Broad Street Hospital, New York
Brooklyn Hospital, Brooklyn
Brownsville and East New York Hospital, Brooklyn
Buffalo City Hospital, Buffalo
Buffalo General Hospital, Buffalo
Buffalo Hospital of Sisters of Charity, Buffalo
*Bushwick Hospital, Brooklyn
Carson C. Peck Memorial Hospital, Brooklyn
Children's Hospital, Buffalo
Clifton Springs Sanitarium, Clifton Springs
Community Hospital, New York
Coney Island Hospital, Brooklyn
Cumberland Street Hospital, Brooklyn
Ellis Hospital, Schnectady
Flower Hospital, New York
Flushing Hospital and Dispensary, Flushing
Fordham Hospital, New York
French Benevolent Society Hospital, New York
Gouverneur Hospital, New York
Greenpoint Hospital, Brooklyn
Hahnemann Hospital, New York
Harlem Hospital, New York
Highland Hospital, Rochester
Holy Family Hospital, Brooklyn
Homeopathic Hospital, Albany
Hospital of the Good Shepherd, Syracuse
Jewish Hospital, Brooklyn
Kings County Hospital, Brooklyn
Lebanon Hospital, New York
Lenox Hill Hospital, New York
Lincoln Hospital, New York
Long Island College Hospital, Brooklyn
Manhattan Eye, Ear and Throat Hospital, New York
Memorial Hospital, New York
Methodist Episcopal Hospital, Brooklyn
Metropolitan Hospital, New York
Misericordia Hospital, New York
Montifiore Hospital, New York
Mt. St. Mary's Hospital, Niagara Falls
Mt. Sinai Hospital, New York
Mt. Vernon Hospital, Mt. Vernon
New York City Hospital, Blackwell's Island, New York
*New York Eye and Ear Infirmary, New York
New York Foundling Home, New York
New York Hospital, New York
New York Hospital for Ruptured and Crippled, New York
New York Infirmary for Women and Children, New York
New York Nursery and Children's Hospital, New York
New York Orthopedic Hospital, New York
New York Post-Graduate Hospital, New York
New York Skin and Cancer Hospital, New York
*New York State Hospital, West Haverstraw
Niagara Falls Memorial Hospital, Niagara Falls
Norwegian Lutheran Deaconess Hospital, Brooklyn
Oneida County Hospital, Rome
Presbyterian Hospital, New York
Rochester General Hospital, Rochester
Rochester Homeopathic Hospital, Rochester
Roosevelt Hospital, New York
St. Catherine's Hospital, Brooklyn
St. Francis Hospital, New York
St. John's Brooklyn Hospital, Brooklyn
St. John's Hospital, Long Island
St. John's Riverside Hospital, Yonkers
*St. Joseph's Hospital, Syracuse
St. Luke's Hospital, New York
St. Mark's Hospital, New York
St. Mary's Free Hospital for Children, New York
St. Mary's Hospital, Brooklyn
St. Mary's Hospital, Rochester
St. Peter's Hospital, Albany
St. Peter's Hospital, Brooklyn
St. Vincent's Hospital, New York
Samaritan Hospital, Troy
Sloane Hospital for Women, New York
Staten Island Hospital, Tompkinsville
Syracuse Memorial Hospital, Syracuse
Troy Hospital, Troy
Women's Hospital, New York
Wyckoff Heights Hospital, Brooklyn
Yonkers Homeopathic Hospital and Maternity, Yonkers

50 to 100 beds

Anthony N. Brady Maternity Hospital, Albany
*Auburn City Hospital, Auburn
Babies Hospital, New York
Broad Street Hospital, Oneida
Columbus Extension Hospital, New York
Columbus Hospital, New York
Emergency Hospital of Sisters of Charity, Buffalo
Faxton Hospital, Utica
*Frederick Ferris Thompson Hospital, Canandaigua
*General Hospital, Syracuse
Geneva City Hospital, Geneva
Glens Falls Hospital, Glens Falls
*Harbor Hospital, Brooklyn
Jamaica Hospital, Jamaica
Jewish Maternity Hospital, New York
Knickerbocker Hospital, New York
Lawrence Hospital, Bronxville
Mary Immaculate Hospital, Jamaica
Mary McClellan Hospital, Cambridge
*Nassau Hospital, Mineola, Long Island
*Nathan Littauer Hospital, Gloversville
New Rochelle Hospital, New Rochelle
Ossining Hospital, Ossining
Park Avenue Clinical Hospital, Rochester
Peoples Hospital, New York
*Prospect Heights Hospital, Brooklyn
Reconstruction Hospital, New York
St. Bartholomew's Hospital, New York
St. Christopher's Hospital for Babies, Brooklyn
St. Vincent's Hospital, West New Brighton
Saratoga Hospital, Saratoga Springs
*Swedish Hospital, Brooklyn
Williamsburg Hospital, Brooklyn

NORTH CAROLINA

100 or more beds

*James Walker Memorial Hospital, Wilmington
*Presbyterian Hospital, Charlotte
*St. Leo's Hospital, Greensboro
Watts Hospital, West Durham

50 to 100 beds

*Asheville Mission Hospital, Asheville
Atlantic Coast Lines Railroad Hospital, Rocky Mount
Burrus-McCain Hospital, Highpoint
City Memorial Hospital, Winston-Salem
Highsmith Hospital, Fayetteville
*Long's Sanitarium, Statesville
Park View Hospital, Rocky Mount
Rutherford Hospital, Rutherfordton
*Salisbury Hospital, Salisbury

NORTH DAKOTA

100 or more beds

Bismarck Evangelical Deaconess Hospital, Bismarck
*Grand Forks Deaconess Hospital, Grand Forks
St. Alexius Hospital, Bismarck
St. John's Hospital, Fargo
St. Luke's Hospital, Fargo

50 to 100 beds

*St. Joseph's Hospital, Minot
St. Michael's Hospital, Grand Forks

OHIO

100 or more beds

*Aultman Hospital, Canton
Bethesda Hospital, Cincinnati
Christ Hospital, Cincinnati
Cincinnati General Hospital, Cincinnati
City Hospital, Akron
Cleveland City Hospital, Cleveland
Good Samaritan Hospital, Cincinnati
Good Samaritan Hospital, Zanesville
Grant Hospital, Columbus
Hawkes Hospital of Mt. Carmel, Columbus
Huron Road Hospital, Cleveland
Jewish Hospital, Cincinnati
Lakeside Hospital, Cleveland
Lucas County Hospital, Toledo
Mercy Hospital, Hamilton
Mercy Hospital, Toledo
Miami Valley Hospital, Dayton
Mt. Sinai Hospital, Cleveland
*Peoples Hospital, Akron
Protestant Hospital, Columbus
St. Alexis Hospital, Cleveland
St. Elizabeth's Hospital, Dayton
St. Elizabeth's Hospital, Youngstown
St. Francis Hospital, Columbus
St. John's Hospital, Cleveland
*St. Joseph's Hospital, Lorain

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THE LIABILITY OF THE HOSPITAL

By JOHN A. LAPP, Director, Department of Social Action, N. C. W. C., Chicago.

THE term *liability* has an ominous sound. It brings up visions of disaster, financial ruin and bankruptcy. Liability is so terrorizing that men seek protection against its disasters. Liability insurance is now common against most of the risks which people run in this respect. Employers' liability, automobile owners' liability and liability against damage to others in many ways have now made liability and liability insurance well known to all men.

In this discussion of the liability of the hospital we are discussing a subject which has not received the attention it deserves. Hospitals have been more or less immune from liability in the past. Hospital managers are therefore startled when from time to time a court decision fixes definite responsibility upon the hospital for damages which may have been caused to patients or others in the conduct of a hospital.

This was strikingly shown by a recent decision in Ohio which held a hospital responsible and liable for damages to a patient caused by the incompetence of a nurse in its employ. Hospitals particularly in Ohio became much alarmed at the prospect of liability which it opened. Efforts were made to get the supreme court of that state to grant a re-hearing and to reverse its decision. The supreme court, however, stood upon its decision and the same now stands as the final word of the courts of the state of Ohio.

Before going further to the discussion of this case, it would be well to classify hospitals in order that there may be no confusion about the type of hospital which we are discussing. From the standpoint of this discussion, hospitals are classified as: (1) public, including municipal, state and federal hospitals; (2) private, charitable or benevolent institutions, not for profit; and (3) private institutions conducted for profit. It is the second of these groups which is to be discussed in this paper, namely the private, charitable or benevolent hospitals, not for profit. In passing it may be said that public hospitals are in almost all states exempt from liability for damages under the decisions of the courts in this country. The only recourse which is a doubtful one, is to sue personally the superintendent or other officer.

In the case of private hospitals operated for profit, the courts have held such hospitals responsible in the same manner that they would hold any other corporation for profit responsible. Such hospitals being private institutions conducted for profit do not fall within the exemptions of either the public hospitals or the charitable or benevolent hospitals.

Rulings of States Differ

We come then to the discussion of the liability of charitable or benevolent hospitals. Since these hospitals have been conducted as a public service without any possibility of profit to any one, they have been treated generally by the courts in a different and more lenient manner than private corporations conducted for profit would be treated. There is, however, a great diversity of conclusions concerning the liability of such hospitals. This variety extends all the way from almost complete exemption on the one hand, to a rather strict interpretation of liability on the other.

For instance, in the state of Massachusetts, in a case decided in February, 1920 (Roosen vs. Hospital, 126 N. E. 392), the extreme view of exemption from liability was held. The court went so far as to state that "a public charitable hospital is not liable for the negligence of its managers in selecting incompetent subordinate agents, any more than it is for the negligence of subordinate agents selected with care." Thus the court decided no liability could attach to the act of any subordinate, whether that person were competent and selected with care or whether he were incompetent and selected in the full knowledge of his incompetency by the hospital. Decisions in some other states have upheld in whole or in part a similar finding, notably in Tennessee, South Carolina, Michigan and Illinois. The opposite view was expressed by the Ohio court in the recent decision in the case of Taylor vs. Flower Deaconess Home and Hospital, decided January 24, 1922.

In this case the court said: "We are convinced that sound reasons sustain the court to the effect that a public charity should not be held liable for the negligence of a servant in whose selection the hospital and managers have exercised due care. On the other hand such an institution is liable when it fails to exercise such care." This decision follows similar decisions in New York, Texas, Washington, Rhode Island, New Hampshire, Minnesota and Alabama. The New York case mentioned (Goodman vs. Orphan Asylum 165, N. Y. Supp. 149) declared: "The general principle protecting charitable institutions for actions for negligence does not include negligence that results in the choice of incompetent, unskilled or careless servants."

Must Choose Subordinates Carefully

The decisions bring the point down to this,—that practically all states exempt hospitals from liability for damages caused by subordinates, if those subordinates are chosen with due care. A few states make such exemption, even for damages caused by subordinates selected without due care, but the weight of present opinion seems to be that the hospital will be held liable for damages unless it selects its servants with due care.

The protection which has been accorded to charitable hospitals has been, as previously stated, because of the public service which they render. A second reason of equal importance has been that since the funds of the hospital were given in trust for a charitable purpose they could not be diverted to pay judgments and they would be diverted even though the judgment might be paid from earned income from pay patients. Another reason for exemption has been that patients accepting the charity of the hospital were thereby held to waive any rights for damages which might be caused to them. Some courts have overruled these latter contentions and have held that such an exemption would work against the very interests which the donors had in making bequests to the hospital. In one case it was said that "While the public has an interest in the maintenance of a great public charity it also has an interest in seeing that every person and corporation which undertakes the performance of a duty performs it carefully."

A similar holding is the ruling case in England, where it was said that "By the admission of the patient to enjoy in the hospital the gratuitous benefit of its care

a hospital undertakes that the patient while there shall be treated only by experts, whether physicians, surgeons or nurses of whose professional competence the governors have taken reasonable care to assure themselves." This point of view is stated very forcefully in a North Carolina case (Hoke vs. Glenn, 167 N. C. 594) in which it was said: "The beneficiaries of charitable institutions are the poor, who have very little opportunity for selection, and it is the purpose of the founders to give to them skillful and humane treatment. If they are permitted to employ those who are incompetent and unskilled, funds bestowed for beneficence are diverted from their true purpose, and under the form of a charity they become a menace to those for whose benefit they are established." And in the Ohio case heretofore quoted it was declared that exemptions from liability "should be surrounded by such safeguards as will prevent the neglect of a duty which the hospital can and should perform. It cannot watch or control the countless acts and movements of its servants, but it can and should exercise care to see that only careful and competent servants minister to stricken patients who are within its walls. Moreover, while it may well be said that donors of funds for the praiseworthy objects of charitable hospitals do not contemplate the diversion of the fund for the payment of damages for the numerous acts of servants referred to, yet they necessarily realize and appreciate that they give their donations to those who have the management and control of the institution, and that every principle of justice requires that they use care in the development and maintenance of the property and in the selection of servants who have the oversight of patients. In our day there is a general tendency in all persons to resort to hospitals in cases which require surgical operations, or in cases of severe sickness, and for obvious reasons it is desirable that such an institution should neither be held out as devoted solely to the poor nor to the rich, and the degree of care required should in all cases be the same. The same rule should apply to a pay patient as to one who does not pay, and there is general agreement in this proposition."

Does the foregoing place upon the hospital an unduly heavy burden? Does the requirement that the hospital shall exercise due care in the selection of competent assistants create a dangerous liability? That does not appear to me to be the case. It places merely a reasonable requirement upon the hospital that it shall exercise due care in the selection of superintendents, surgeons, nurses and attendants. It does not ask of them that they do the impossible. A servant may be hired who is incompetent and unless the hospital managers in the exercise of due care knew or should have known that the person was incompetent, the hospital would not be liable. Thus, for example, a man might be hired as an ambulance driver who had epileptic seizures; the hospital necessarily would not be liable unless it knew that fact. It would be liable if it retained such a man in its employ as an ambulance driver after the facts became known.

A hospital might reasonably employ a physician by virtue of his license from the state to practice medicine without running a risk of liability, but if it should be discovered that such physician were incompetent or negligent, the hospital would be liable thereafter if it retained such man in its employ. How far this rule would apply to physicians who serve upon the staff of a hospital without being in the employ of the hospital, I am not prepared at this time to say. The hospital could not be held liable if a physician is negligent in treating his own patient who is brought into the hospital, which is acting in the capacity of a hotel for the sick. It is not so clear, if the physician is on the staff of the hospital and treats a patient brought to the hospital, not as a private patient, but as a patient of the hospital.

It seems clear that the hospital would be responsible for acts of its superintendent or subordinate agent for grossly incompetent care if it were evident that the board of managers knew of the incompetence of such superintendent or subordinate agent. Of course unreasonable requirements cannot be enforced upon a hospital. Neither a hospital nor a physician is liable for a failure to give the best that the world affords. They are required to give the best, at least that the facilities and medical knowledge of the immediate community afford. A hospital in a small town remote from great medical centers would therefore not be held responsible for as many things, as would one located in a metropolitan center. If the hospital does the best it can with the lights and facilities it has, the rule of reason is satisfied. Hospitals and physicians should not be held responsible for acts or omissions when in the exercise of their judgment they did what they considered the best for the patient. Failure to perform an operation, though a post mortem should disclose that an operation would have saved the life of the patient, could not and of course should not create liability. Lack of supreme knowledge or mistakes in medical judgment cannot create liability.

In concluding this paper, which has necessarily been of general application, rather than of specific cases and types of liability, it seems fitting to suggest the relationship between certain proposed legislation and the liability of charitable hospitals.

It is perfectly clear that the liability of the hospital is increasing. It is perfectly clear also that such liability will continue to increase. If the hospital is to be held liable for negligence in the performance of its duties, especially because of its failure to select competent physicians, surgeons, nurses and attendants, then it would be wholly wrong and clearly unconstitutional for a legislature to attempt to compel a hospital to open its staff to all physicians entitled to practice medicine in any given community, as was proposed by bills introduced in various state legislatures during the past two years.

If the legislature can compel a hospital to put chiropractors on its staff, then the hospital could not be held liable justly for damages. The converse of this is also true, that if a hospital is held liable for negligent and incompetent agents, no other power but its own managers can have anything to say concerning the selection of those who are to perform the work of the hospital.

What should the hospital do about its legal liability? In the first place it should not get alarmed. The liability of a properly run hospital is very slight. Liability to damages may force upon trustees and managers greater attention to the trust which has been imposed upon them, but if their duties are properly performed there is slight cause for fear. On the other hand a hospital which is not properly run, a hospital which has a reputation for slovenly work and unsanitary conditions may well look to its liability.

Should the charitable hospital insure against liability? Yes, but not at exorbitant rates. Clearly the liability is slight in the average well managed hospital. Rates of insurance should therefore be extremely low.

May I suggest that insurance against liability may be provided best by a hospital mutual insurance company operating at cost by the hospitals themselves, thus following the example of numerous lines of business where such a plan is in successful operation?

A FINANCIAL BASIS FOR EXTENDING THE WORK OF THE GRADUATE NURSE TO THE WHOLE PEOPLE

By RICHARDS M. BRADLEY, Trustee of the Thomas Thompson Trust, Boston, Mass.

As a layman and a business man, I wish to speak on certain economic aspects of the nursing profession, in the belief that until certain economic defects in the present methods of nursing service are recognized and dealt with by nurses and their leaders, those features of the situation which everyone knows are unsatisfactory will continue, and will not be remedied by the many efforts, legislative and otherwise, that have absorbed much of the collective energy of the profession.

For more than twenty years, in connection with the use of money in dealing with the exigencies of sickness and maternity (having had occasion to expend for this purpose many hundred thousand dollars and having dealt with very many individual cases), I have come in contact with much nursing work in its direct application to the people. In this I have seen many able and noble women expending themselves to alleviate sickness and suffering and have seen many of them insufficiently compensated, not only in money but in results; therefore I feel I may not remain silent if anything can help which may be contributed from one able to look at the matter from a somewhat different angle, the economic and financial side as contrasted with the technical and professional side.

Financial System is Primitive

It has been discovered lately that in all therapeutic work, the technical advance has gone ahead of progress in financial and organization lines, and steps are being taken in certain directions to remedy this. It would be a great misfortune if in this the graduate nurse was left out of consideration, and I therefore wish to indicate how she has been injured, and how she should come in, when dealing with plans for remedy.

Our general problem of care in sickness and maternity involves the application of modern methods to a population about 80 per cent of which belongs to the class called independent persons of moderate means.

According to recent estimates, the body of people with incomes of $2,000, or less, received about 60 per cent of the gross annual income of the country, or some $37,000,000,000 more or less. Since members of this class largely support the country, they must necessarily carry their own expenses, and success in giving them the advantage of modern therapeutic methods must therefore depend upon diverting an adequate part of their own income to this purpose.

Our trouble is that we are trying to operate with an old financial system that is too primitive for modern requirements.

Formerly, the ordinary family looked almost entirely to the family doctor and to the practical nurse in the emergencies of sickness and maternity, and although many lives were lost that would now be preserved, and much suffering and disability went without remedy, the financial problem was comparatively simple and was settled between the parties on personal lines. The case is different now. We have the hospital, the specialist, the surgeon, and the graduate nurse, all necessary if life and health are to be preserved, but all involving exceptional expenses.

These expenses are not of the class called regular living expenses, such as food, clothing, rent, etc., but are of what might be called the catastrophe class, like fire or accident, striking here and there and involving exceptional families at irregular times in great expenses.

They are, however, expenses that can perfectly well be met through the benefit payment or insurance method, by distributing the exceptional loss over many families and over longer periods of payments, as is done with regard to other similar expenses and as is done for certain kinds of nursing service for the poorest part of the population by the Metropolitan Insurance Company.

In this connection, I find that there is an idea that such liabilities are covered for other classes by ordinary insurance underwritings, but so far as I can ascertain such policies are very limited in their number, seldom cover service to be rendered in sickness but merely loss of earnings, and seldom even then cover more than what happens to the income earner and not what happens to the earner's dependents.

Now, what is the effect of this condition of affairs upon the various modern agencies that have sprung up to handle sickness, especially the hospital, the specialist, the surgeon and the graduate nurse?

The hospital trustee and the nursing organization committee pass around the hat with intensified effort to meet their mounting deficit. Their endeavors in too many cases fall short and have the added disadvantage of undertaking to fulfill a vital public function that cannot be adequately discharged by the contribution method. In many cases they have lamentably failed in seasons of stress. They are conducting a great and important public industry without adequate financial foundation, and they are too often confronted with the alternative of not doing necessary work or inflicting great apparent hardship by charging heavily for it. This last may also be said of the hospitals that are supported largely through payments made by their patients.

The surgeon and the specialist have evolved the practice of charging Peter for the service of Paul. The difficulty of this method, apart from the liability to abuse, is that he can no longer extract from his richer patient sufficient to give adequate service to the poorer.

The result of all this has been inadequate service, hardship and general public dissatisfaction, and I have personally seen the hard-earned results of many years' saving swept away, and independent families reduced to suffering and dependence, all through perfectly legitimate charges for services rendered by hospitals and doctors and nurses.

Nurse Deprived of Birthright

Now when does the graduate nurse find herself affected by this state of affairs? *I think it may be said that she is deprived of her birthright.* Her place is at the bedside of thousands and thousands of difficult and critical, often desperate cases, throughout the country where she is now unknown and often not even thought of. She cannot find full happiness and satisfaction in her work till this reproach is removed for which she is not to blame.

We have in the newly graduated nurse a young woman sent out from her place of education after giving three

or four of her best years to preparation ostensibly to do work that is now financially inaccessible in 80 per cent of the cases where it ought to be done. It is work at which she can probably not labor more than two-thirds of her time and retain her health and strength, and whether her hours be made longer or shorter, the years in which she can give her best powers are limited. In order to provide for herself and for her dependents, she must be adequately paid and that adequate pay must be a great expense at whatever amount it is finally placed.

She is not needed for all the cases of sickness; there are many that can be cared for by others (and should be so cared for) under her direction, and there is much work that has got to be done in the families of the sick that she cannot and should not do. But there *is* work that she should and must do in this great field all over the country now closed to her, a field that calls for all and more than all the graduates can do were that work properly organized and financed.

It is no satisfaction to her to see the morale of her profession undermined, by having the members in private nursing diverted to coddling the elderly rich or caring for the children of wealthy families in order that the mothers may shed their cares and travel, when she knows that in thousands of humble homes her services are needed by those who are suffering and dying for the lack of the skilled nursing that she alone can give. It is no satisfaction for her to find that in much organized nursing she is the paupers' rather than the people's nurse, and that the program laid out cannot possibly cover the people's needs.

Legislation Is Not Remedy

As to the remedy. It is no remedy to rely on legislation, for no more limiting of the numbers of women who do nursing will remedy the trouble. The way to overcome illegitimate competition of this kind is to do the work properly that has got to be done or to see that it is properly done. Moreover, there are none too many laborers in the field, and many now working there, if rightly organized and directed, would find a proper outlet for their energies and do their work better.

It is useless to turn to organized nursing as at present usually conducted, for that too, in spite of the examples afforded mostly in other countries, makes little or no provision for benefit payments (except through the Metropolitan).

In Chicago, all but 13 per cent of organized nursing work depends on contributions and is limited in amount by what can be so raised. Boston is a little better but not much, and St. Paul until recently was entirely charitable as to its organized nursing. These are types. This organized work was originally started as charity, and in spite of certain valuable demonstrations, its progress in getting out to the people has at times seemed hopelessly slow; it also needs the same remedy in the same way of distributing the burden through benefit payments.

As to the nursing and medical professions, the work of properly organizing the finances of therapeutic work in this country can hardly be put upon persons whose entire energies must necessarily be taken up by technical and administrative work. The most that can be asked of them is that they shall not insist upon impossible financial methods for accomplishing that which they wish to have done.

The point of attack is the business and financial people who are responsible for your hospitals and nursing organizations. What is needed from them is less philanthropy and check drawing and more of the business brains that they give to other things. They must organize insurance and benefit payment, so that the people's needs can be met out of their own pockets. You should tell them that if they want young women to enter hospitals and become nurses, they must organize the finances of nursing so that she can do her work where she is needed when she graduates. They must do this just as they must reorganize the finances of their own hospital and surgery work, so that the ordinary independent citizen can pay for what he needs to have supplied. Otherwise—and they are beginning to know it—they will have the whole thing taken over by the state and thrown into politics.

There are signs of better things. I hope you will watch the Henry Street work in New York, and the Missouri Valley Hospital in Kansas City, where the attempt is being made to enable people of moderate means to finance their emergency service from their own pockets. In Brattleboro, Vt., where we have at the present time a highly developed system of service for a town and country district both for home and hospital, we hope to inaugurate a system whereby it will no longer be necessary to curtail service or to create financial distress in furnishing adequate service to each case.

There is only one way out. It is no more possible to supply the people with modern service in sickness by our present methods than to pay for their fuel and groceries by passing around the hat, or to expect them to meet the cost of occasional fires out of their current income. The whole therapeutic system is debauched by outworn charity traditions that impede its true progress, and a change is demanded. There is much money in the pockets of the people available for less important things, and it can be made available for this that is vitally important if we go to it. When the change comes I hope that the nursing profession will not let itself be left out of the going. I hope that it will be ready; and ready to lend a hand in the forming of local benefit associations to pay for hospital and nursing service, so that not only will the hospital and the specialist be provided for, but we shall have a graduate nurse available in every home when she is most needed.

WESTERN MEDICINE PROGRESSES IN CHINA

"Looking back over the past ten years," says Mr. Roger S. Greene, in his report as director of the China Medical Board of the Rockefeller Foundation, "it is clear that medicine in China has made real progress. The increased effectiveness of medical schools and hospitals, the development of an active Chinese medical association under enlightened leadership, and the growing interest of the Chinese people in Western medicine and public health, are sources of satisfaction to those who hope to see the Chinese people in possession of a scientific, well-rounded, and complete system of medicine."

Striking evidence that the pioneer work of foreign schools and colleges in China is bearing fruit is also found in the organization in 1921 of a purely Chinese national association.

TO SUPERINTEND MILFORD HOSPITAL

Miss Eileen Curley, former assistant superintendent of the Morton Hospital, Taunton, Mass., has been chosen superintendent of Milford Hospital at Milford, Mass., to succeed Miss Ellen Conrick, who has resigned and will soon marry Dr. J. V. Gallagher of that city. Miss Curley has been second in charge at Morton Hospital for four years. She is a graduate of the Massachusetts General Hospital, Boston.

NEAR EAST RELIEF HOSPITALS IN CONSTANTINOPLE

By ELIZABETH KNOWLTON, Near East Relief, New York, N. Y.

CONSTANTINOPLE—the very word suggests to us all the picturesque dirt and the crowded, unsanitary, colorful life of the Orient. But in this city of romance and refugees the Near East Relief has built up in the last two years a health organization that would do credit to any town in the United States.

Over two years ago an American doctor, Dr. Elfie Richard Graff, was asked by the Near East Relief to make a general survey of conditions and needs in Constantinople. At that time there was almost no work done for the poor and ill. There were several large districts where there were not even any native doctors to call upon. Now under the Near East Relief are a case work committee, three clinics and two hospitals.

The case work committee cares for the children of needy mothers, especially war widows. The native directress of each of its forty-four districts, before she gives aid of food or clothes, calls on the children in their homes, and refers those who need medical attention to the Near East Relief clinics and hospitals. This committee gave help to over 11,200 children in the last half-year.

Clinics conducted are divided into three groups, the adult clinics with almost 900 patients in six months, the child welfare clinics with 7,200, and the trachoma clinics with over 15,000.

Everywhere throughout its field of work the Near East Relief is valiantly fighting trachoma. That blinding disease always to be found in the Orient and accepted by the natives as something unpleasant but inevitable, like fleas, has lately, thanks to wars and deportations, become appallingly prevalent. All the conditions of refugee life encourage it—the extra dirt, the overcrowding, the malnutrition—and Constantinople is nowadays a city of refugees. So one of the two hospitals conducted there by the Near East Relief is a Trachoma Hospital.

Grand Vizier's Palace Becomes Hospital

Hospitals in the Orient are not necessarily just like ours here. This one happens to be the former palace of Riza Pasha, Grand Vizier of Abdul Hamid. It is situated just outside Constantinople on the shores of the bright-blue Bosphorus, a picturesque, rambling building with many windows, almost hidden from the land by the trees and shrubs of its famous terraced gardens. These gardens, where the ladies of the great Pasha's harem once took the air in safe seclusion, are now the playground of 225 lively orphans.

The Trachoma Hospital is under the supervision of Miss Emma Cushman, a woman of striking personality, the possessor of the Queen Alexandra War Medal, the Gold Cross of Jerusalem and the French Legion of Honor for philanthropic work. She is assisted by native nurses, trained for this work by Americans in the hospital. Their young patients represent almost all the nations gathered in that cosmopolitan city, Armenians, Greeks and Jews, Turks, Syrians and Chaldeans. For the Near East Relief takes children for treatment from all the national orphanages of Constantinople.

They live the lives of normal healthy children, except for the painful treatments which are necessary to cure trachoma. These come twice a day for each orphan; and every other day the American doctor comes and operates on those who would be benefitted. This is not to the children the terrible occasion that might be expected. It is told of one youngster who when examined was found in too poor general condition to stand the strain, that he went to bed that night crying, because he had been denied his operation!

Little Patients Govern Selves

For the rest, the children have a busy, happy time of it. They work in the school which is conducted for them, help with tasks around the house and grounds, dig in the Grand Vizier's magnificent garden, and go swimming in the Bosphorus under their windows. It may be imagined that to keep in order 225 active children in fine physical condition is no easy job. So a canny plan of self-government has been evolved. The children are divided into groups of ten, and out of each group is chosen a leader. He is invested with a red armband, as badge of authority and honor, and is held responsible for the good behavior of this group. If he cannot keep order, he is removed and another leader appointed.

In general, there is surprisingly little "race rioting" for such a mixed lot, and what there is, the head puts down with a firm hand. "A Greek is no better than a Turk!" says Miss Cushman sharply, as she separates the warring parties, probably giving them both a good shaking in the process. "Remember that, children! A Greek is no better than a Turk! A Turk is no better than a Greek!"

The Near East Relief Trachoma Hospital on the shores of the Bosphorus, formerly the palace of the Grand Vizier of Abdul Hamid.

American sailors at Constantinople give party to Armenian orphans at Near East Tubercular Hospital.

Greek, Armenian and Russian nurses at the Near East Relief Tubercular Hospital.

Receiving guests at the Vedi Koli Tubercular Hospital

Life at the other Near East Relief hospital, that for tuberculous children, is of necessity more peaceful. There a third of the young patients are confined to bed, and many others hop around on crutches, as the most common form of tuberculosis with them is tuberculosis of the bones or joints, the indirect result of prolonged malnutrition.

Their hospital is less romantic than the other, and has a more medical atmosphere. Driving out of the Adrianople gate, you pass through fields of cabbages that make it seem like real country, till you come to the group of buildings that make up the Yedi Koule Tubercular Hospital. Before the war a Greek hospital, and now given to the Near East Relief, this institution is one of the best, in building and equipment, of any in the Constantinople district. The 115 children live in very modern-looking cottages, with screened sleeping porches where their beds are placed, and a big outdoor dining-room for the warm season. But medical equipment in the Near East is at the best not adequate. Though this hospital compares so favorably with most, it lacks many necessary articles, and they have to be improvised out of the materials at hand, as are the weights for a head or leg extension, which are made from American lard pails filled with sand.

This hospital, which is partly supported by Canadian gifts, has for its head Miss Emma M. Wood, a Canadian nurse, who received part of her training at Johns Hopkins. She has trained the nurses under her, Russians, Armenians and Greeks, who twenty months ago had had no experience. Now, she boasts, they "do all the nursing, make all the dressings, give the medicines and have entire charge of treatments and chartings, and are also able to put up either a head or a leg extension."

"Gobs" Scatter Happiness

The children here are a younger group than those at the Trachoma Hospital, very few of them being over twelve. In spite of deformed joints and twisted limbs, they are as happy, plump and smiling as any youngsters you often see. In fact, they are luckier than most little American patients, for they are the fortunate possessors of a countless number of fairy godfathers in the shape of American "gobs." Some American ship is always stationed at Constantinople, and the American Sailors' Club delights in giving them a good time. Every spring it invites all who are able to go, to the camp for a picnic, and last year seventy fortunate youngsters enjoyed a glorious day of games and "eats" with their sailor friends. At Christmas the Sailors' Club played Santa Claus, and this Easter it gave the children money to make gardens, where poppies, daisies and pansies are flourishing, delighting their color-loving little souls. And frequently the long lonely days of the sick children are cheered by visits from jolly "gobs," and by gifts of candy and toys. That the children are not lacking in gratitude for this kindness, defining gratitude as "a lively sense of favors to come," was shown plainly in a "thank-you" letter they composed, which ended with the naive expression, "We hope our sailors will be so kind as to make us enjoy on other occasions also. Thanks in advance!"

Washing the eyelids—a trachoma treatment. You would never guess from the patient pose that the treatment is extremely painful.

So, here as always, we see the name America winning love and affection from the people. Thanks to this feeling, the medical work of the Near East Relief in Constantinople and elsewhere is beginning to bring to the natives the American taste for cleanliness and fresh air, and is teaching native nurses American methods of coping with trachoma, tuberculosis and other diseases. The work is carried on always with an eye to the future, and it is hoped that at an early date the Trachoma Hospital may be made unnecessary by the introduction of the modern treatment, with American-trained nurses to give it, into all the national orphanages, from which the hospital now draws practically all of its patients.

THE HOSPITALS AND CANCER CONTROL

By FRANCIS CARTER WOOD, Director, Institute of Cancer Research, Columbia University, New York.

CANCER Week is announced by the American Society for the Control of Cancer to begin November 12. The motives behind this new movement in public health propaganda are extremely simple. They are based upon the fact that 90,000 people die of cancer in the United States every year, and that many could be saved by proper treatment; that surgery, radium, and x-ray are not at the present time very effective in late cancer and most patients consult their physicians at a stage in the course of the disease where all curative therapy is without avail and only palliative results can be obtained. If the people of this country can be educated to consult a doctor while a cancer is still early, many of them could be cured.

What can the hospitals do to help in the propaganda against cancer?

1. They can see to it that adequate histories are taken on cancer patients. An inspection of most hospital records shows that the histories of cancer patients, while supplying an abundance of unimportant details, are defective in many vital points. I have not been able to find, for example, in a very large series of histories, any facts which enable conclusions to be drawn as to the lapse of time from the first appearance of the growth to consultation with the physician, or what is also important, the time from the seeing of the physician until admission to the hospital. It is imperative for the control of cancer that these two periods be shortened as much as possible, but the histories are generally silent on the subject. Many patients have been treated by the dietary, physicotherapeutic or mind-cure quacks for months before consulting a physician. Such data are rarely found in histories, but are important if made public in leading to the possibility of some regulation or suppression of the irregular practitioner.

Should Keep Slide as Record

2. The hospital authorities should provide for the routine microscopic examination of all pathological material. A not inconsiderable proportion of the lymph nodes exercised from the neck and diagnosed as tuberculosis are really cancerous. Ulcerative lesions of the bowels thought to be merely inflammatory are occasionally malignant. Frequent slips are made in diagnosing borderline breast tumors. In many cases a carcinoma of the uterus is not found because the curettings or similar material removed in the operating room are not submitted to a microscopic examination. Not only the diagnosis, but also the prognosis, depends greatly upon examination of the tumor material removed. It is the duty of every hospital to see that all these examinations are made, and that a microscopic slide is preserved from every case. The slide record is much more important than a long and wordy description of miscroscopic findings.

3. Hospital authorities should do everything they can to encourage autopsies. The present low recorded death rate from cancer in the United States is due partly to the fact that many obscure abdominal cancers escape diagnosis. Within the past year I have seen four cases of carcinoma of the stomach which failed of diagnosis by some of the most expert physicians in the city of New York only to be revealed at autopsy.

4. The hospital should see that cases of cancer are reported, as such. The family too often asks that the diagnosis of cancer be not written against the patient's name, but that a terminal pneumonia or some other immediate cause of death be placed on the certificate. The practice should be frowned upon.

5. The establishment and development of follow-up clinics are exceedingly important in regard to the ultimate result of the operative work of cancer. In the larger cities the surgeon is too often liable to retain an optimistic attitude toward his operative work on cancer because he loses sight of his patients. The follow-up clinic which brings patients back for observation for a considerable period will often show the results are not as satisfactory as they promised. The best adjunct of the follow-up is a radio-therapeutic clinic because the patients who receive post-operative radiation feel that they are getting some care from the hospital itself, and hence are much more likely to return for post-operative raying, and the end results are determinable. Such clinics can be made self-supporting.

6. The social service nurses should have impressed upon them the importance of spreading the simpler facts concerning the nature of cancer. They come in intimate contact with the families of patients and are often in a position to make a tentative diagnosis. They should attend the lectures of the American Society for the Control of Cancer, and obtain the necessary literature by writing to the society, 370 Seventh avenue, New York, and familiarize themselves with the methods of spreading proper information concerning cancer.

7. The attending staff of the hospital should conduct diagnostic clinics on cancer both during Cancer Week and at other times, not only for their own intellectual profit, but also in order to educate the house staff and instruct the physicians, who send their patients to the hospital, in the modern methods of diagnosis and the results of modern therapeutic methods as applied to cancer. It is not easy to tell a brother practitioner that he has been worse than a fool to treat a cancer of the breast by diet and massage, but it is easy to demonstrate the fact if the patient is shown in a clinic.

8. So much for those patients who are within the doors of the hospital. The saddest sight is the patient who is turned from an institution because a cursory examination has led some recent graduate to decide that he is inoperable. This should not be. Many cases which have been refused admission and told vaguely to go somewhere and take x-ray or radium, naturally feel that there is no hope and drift into the hands of the ever-present quack. Many of them are really not operable. The determination of the operability or non-operability of a case of carcinoma is often a matter of the most careful judgment and should be referred to some senior member of the staff. If operable, the patient should be given a letter referring him to some institution where proper palliative radium or x-ray treatment can be carried out, assuming that the hospital itself has no such facilities.

"The basis for all publicity is the usefulness, need and value of the thing advertised. Our apologia must be sound and convincing."—Ralph Welles Keeler.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
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THE ROLE OF THE HOSPITAL NURSING DEPARTMENT IN THE COMMUNITY HEALTH PROGRAM*

BY ANNIE W. GOODRICH, R.N., DIRECTOR OF NURSING, HENRY STREET SETTLEMENT, NEW YORK CITY.

I SHALL have to ask to deal rather with the role of the hospital, than the hospital nursing department, in the community health program, for the part of any department is inevitably bound up, or certainly to a very great extent dependent, upon the policy of the whole.

Further I must add that I am suffering from a profound awareness of my inability to present in other than slightly differing phraseology what has been said forcefully, frequently and convincingly by the various specialists in the new field of preventive medicine, beginning with the public health nurse whose maiden speech dealt with the inadequacy of the hospital training for the field of public health nursing.

Each in turn has been convinced, and rightly, of the need of every practitioner of medicine and nursing of first-hand knowledge of their specialties and a broader interpretation of their function in the health field at large until we have reached a final summing up of the discussion in the exhaustive analysis of the Rockefeller-Goldmark report on nursing education—its weaknesses and strengths —on the one hand; and on the other, the briefer but broad conception of the hospital function in the health movement through the report on the principles of hospital administration and the training of hospital executives by Dr. Willard C. Rappleye.

Society Still Indifferent to Health Needs

There are some who do not agree on the importance of the hospital in the new health conception. For ourselves, it matters not how intense or intelligent is our appreciation of the new outlook on health sublimated recently into the term "positive health," or that we are in complete agreement on the importance of approaching the subject of health from the normal rather than the abnormal standpoint; nevertheless we still have to deal in the matter of the health of the community with certain facts, such for instance as:

a. The tendency of all normal individuals, rich or poor, to be indifferent to the subject of health until rapped into attention by the handicap of some defect, personal or with some individual with whom they are concerned.

b. That the prevalency of defects has brought all classes of society to recognize, even to demand, the service of those health agents designated as physicians, nurses and dentists, this fact giving these practitioners the opportunity of wide and frequent contact and the advantages of accepted authorities

c. The defectives in any given unit of population increase in almost direct ratio with the decrease in the wage scale which connotes a decreasing body of knowledge (I refuse to say intelligence) as well as opportunity concerning the procedure necessary to change the situation. "The destruction of the poor," said Solomon, "is their poverty."

d. Only a comparatively small number appear to be ready as yet to subscribe to the practice of preventive medicine, even though believing in the theory. Evidence of this may be found in the failure to support such measures as the Sheppard-Towner Bill, or the peace program of the Red Cross, and in the still general habit of institutions and organizations, primarily concerned in the care of the sick, to limit their function to a given situation and to fail to assume the responsibility of health education relating to such a situation.

The following illustrates these facts:—The young wife of a professor called for advice and assistance concerning her new-born baby that had cried all night. She stated that she had just returned from the maternity hospital and that she was totally ignorant as to the child's care, such as bathing and diet. She had called the visiting nurse service and was told that it was impossible to send a nurse as the organization was obliged to give precedence to sickness cases, and the daily program was more than filled.

In this episode we have an almost complete picture, the young mother not alertly seeking information before leaving the institution. Not until something went wrong with the baby did she awaken to her educational needs, while the hospital and the visiting nurse service were functioning in exact accordance with the tenets of curative not preventive medicine.

The preceding facts seem to me to summarize as follows: the prevalency of defects; the place in the family life accorded physicians and nurses by a society still indifferent to its health needs; the scientific equipment as expressed in hospital machinery and personnel now required for the effective dealing with defects; the increasing use of these institutions for the maternity case; and their continued and extending use as laboratories for the preparation of health workers of varying types. All of these things demand that the hospital, of strategic importance in health problems, function either as the health center within a given area or at least as a definite link in the chain of health activities required for a community health project. To do this effectively, however, will necessitate reconstruction of its program, method and system.

Mr. Bailey Burritt of the Association for Improving the Condition of the Poor in writing on "The Family as a Unit in the Control of Disease" opens his paper with the statement that "public health nurses and public health authorities must increasingly take the family into account

*Read before the twenty-fourth annual conference of the American Hospital Association at Atlantic City, N. J., Sept. 25-28.

if we are to hope for further substantial reductions in morbidity and mortality rates, and particularly if we are to hope for marked progress toward the goal of making every individual a strong, healthy, able-bodied citizen over a considerable period of years."[1]

Family the Unit of Responsibility

Making of the family the unit of hospital responsibility, if consistently carried out, will require that the entire personnel of the institution shall experience that life within its walls that will most effectively and enduringly impress upon them the essentials in health habits for their personal life, not less than for the lives they are directing or being prepared to direct.

One is tempted to digress, if digression it should be called, to discuss the changes that would immediately be effected if the hospital interpreted its case responsibility as extending to its large and varied personnel and in the terms of the family rather than of the individual.

The consideration and direction, for instance, of the life of the interns, their hours, their housing, their diet. I recall a recent recital by an overstrained intern of consecutive days and nights of service with its attendant complications of sleep and food, and my mind is crowded with memories of conditions reacting disastrously upon the patients as well as the hospital personnel, which a health program for all might have averted.

The assuming of the family as the unit of responsibility would bring about other much needed adjustments, the most outstanding of which would be the limitation of each hospital's functions to a given area or unit of population with a resultant coordination and correlation of all health agencies, educational or remedial.

Progress in the direction of this unification idea there has been. The slow but steady development of central schools of nursing, the growing relationship between the school of nursing and the university, the increasing cooperation between social and health organizations, the numerous experiments, such as, that of Framingham and Mansfield, are definite achievements toward this end, but in relation to the output of convincing presentation of the need as expressed by progressive social and health authorities, and in the face of the possibilities for rapid and great achievements through complete unification of means and ends, they are agonizingly slow and intolerably aloof.

It has been said that "the real task for workers in the field of mental hygiene is translating insight into influence," so also might it well be said concerning the task of all health workers, for despite these evidences of progress almost incredible situations exist through a failure to act in terms of community development and well-being.

Sees Folly in Sending Students to Distant School

In the light of present-day knowledge surely a local situation is astounding that results in sending students of a school of nursing in a state having a population of 2,500,000 (which would represent approximately 1,000,000 children) to the eastern coast year after year for a course in pediatrics, or in sending students in a city having a population of approximately 700,000 (which means over 14,000 births yearly) to an adjoining city for a course in obstetrics. One hesitates to call attention to these facts lest students be withdrawn from the distant institutions and thereby lose the opportunity of an essential experience, but, on the other hand, the loss to the locality of needed service and the economy of time and money which a different adjustment would mean demands careful consideration and a speedy solution of the problem.

1. Public Health Nurses' Bulletin--August, 1922.

In one city of something over 200,000 which means approximately 100,000 children maintaining several schools of nursing, with the exception of one school, almost none of the students was receiving a course in pediatrics. The one school was sending its students for a month's experience to another institution. It was true that the infant mortality in that city was low, but on the other hand, in its two tuberculosis sanatoriums were to be found a rather large number of children ranging anywhere from one to fifteen years. The heaviest age group in its state hospital for the insane was from twenty to twenty-five years. There was one institution for children with an approximately fifty-bed capacity mainly for orthopedic cases but that had enlarged its service to include medical cases, and was doing rather an interesting piece of work with syphilis.

Students are deprived of experience, or service is not rendered, mainly because of a wrong point of view as to the relation between these organizations and institutions and the community at large, the keynote of which is struck in the still frequent phrase, "our school, our patients, our family." What creates ownership of students, of patients, or families? Education for which the students pay in service or money, sickness care rendered to a particular member, relief given for a particular case.

Born of philanthropy rather than coming into existence through the felt need of the members of the community, these organizations and institutions, finest flowers as it were of a passing system which have indeed sown the seeds of the new social order, nevertheless to serve effectively, indeed to survive in a democracy, must know themselves to be responsible *to* the community, not *for* the community whom they serve. Their roots today must be sunk deep in *conscious community ownership* in order that they may receive the support—moral and financial—for effective functioning.[2]

Cooperative Health Insurance Schemes

Here too, in the matter of financial community support we can also strike an optimistic note for we find evidence of development; in the most experimental stage, it is true, but nevertheless quite definite.

In a recent issue of a magazine called *Cooperation*, we find the following:

"Since 1904, the workers of Madrid, Spain, have maintained a health department in the cooperative society (La Mutualidad Obrera). This provides complete medical service for eight dollars a year for each member. There are seven clinic-hospitals in different parts of the city, each equipped with about ten beds, an up-to-date operating room, a dental clinic, consulting rooms, an immaculate tiled kitchen, and a garden for convalescents. Each has a staff of physicians, surgeons and nurses. The drug store connected with each hospital furnishes medicines free of charge to the members, and sells to non-members at the current price. The cooperative society supplies the hospitals with provisions. Each member pays 66 cents a month to the society. For this, besides the benefits of membership, he receives free medical service, major operations, consultation and advice at any time."[3]

Again in the city of New York under the title of the Manhattanville Health Society an experiment[4] of this nature is being carried on based on the computation of three organizations that their service is subscribed to by 5,000 people could be supported at the rate of $6.00 per capita subscription.

We are quite confident that when the hospital assumes the place in the health program which Dr. Rappleye has so justly assigned it the many greatly needed readjustments will speedily follow.

"Position of the Hospital—The common ground upon which the patient, the community and the professional groups meet and represent-

2. It is the author's belief that an effective transfer from philanthropic to governmental support is not possible because of the present tendency to control through symbol rather than *intelligent* common consent; the subject of symbols has been ably dealt with by Walter Lippman in Public Opinion, Part 5.

3. Cooperation, October, 1922.

4. The plan for this health project was evolved by Ella Phillips Crandall, recently executive secretary of the National Organization for Public Health Nursing, and is subsidized by an unknown donor.

ing the general type of organization which, with proper amplification and development, can best meet the problems suggested, is the hospital. It evidently occupies a strategic mid-position and has open to it a great opportunity and a corresponding obligation, not as an institution for the salvage of human wreckage but as a coordinator of activities—professional, economic and social—in their application upon the problems of health. In such a conception, the hospital represents not the administration alone but a cooperative organization of workers and leaders devoted to the ideals of their respective professions."[5]

The tendency of physicians and nurses to overemphasize the physical aspects of the case, with their resulting disregard or minimizing of the social factors directly affecting it, has been advanced as a distinct handicap in their effective functioning as health workers. This has been given indeed as one of the important reasons for the creation of social workers without medical or nursing training. A careful consideration of the question leads to the conclusion that, while fully accepting the fact of this tendency and also the place in the health program of this type of social worker, this is not the best solution of the difficulty.

Social Training of Health Workers

The purpose of a hospital or dispensary is to meet the need of physically or mentally defective individuals whatever may be the contributing or underlying cause of such defects. Beginning with the chief executive down through the various departments wherever the medical situation dominates there is definitely required a medical or nursing personnel. In the cause of effective and economic service, such personnel should be relieved as far as possible of the non-medical features of the case through the service of other workers skilled in such features; not less also in the cause of economic efficiency should the medical workers be expected to have such knowledge of the non-medical aspects of the case as to understand the importance of their relation and furthermore to deal with such aspects where the body of the work will not justify the two specialists.

This implies a knowledge of the technique of case work for both physicians and nurses. It will very possibly be taught more effectively by a social worker than a physician or nurse but whoever teaches the subject, let me add, will probably do so with better effect if prepared through a course in teaching methods. The same could be said concerning the technique or the science, for such it has come to be, of administration. Such knowledge should be required of every administrator today, but to select a physician merely because of such knowledge to administer a business house or to select a business man to administer a hospital is, we believe, poor judgment because of the waste of medical knowledge on the one hand and the handicap of the lack of it on the other. It would, however, be equally poor judgment to appoint as the chief executive for either position a person with a predominantly research type of mind. In the personnel of the business concern of today would probably be included physicians and nurses while the personnel of all modern hospitals includes nutrition workers, statisticians, librarians, accountants, engineers, and an almost endless variety of medical and non-medical workers.

In short, the purpose or function of an institution should determine not only the type but the relation and distribution of its personnel. Whatever may be the process or processes through which the result sought may ultimately be effected, it is desirable that a person seeking such result through an institution created for the attainment of that end should be as immediately as possible related to those whose discernment in the matter has been "sharpened to a point" through training and experience. The failure to appreciate the importance of such adjustments has been and still is one of the outstanding weaknesses of hospitals and dispensaries due mainly to an inadequacy of funds and ipso facto an insufficient and inefficient personnel.

The introduction and rapidly increasing number of private patients, since *their* demands must be given consideration, have been beneficial but the overcrowding and understaffing of departments, such as dispensaries and public wards still obtains. Personally we do not believe that the development of new types of workers is needed so much as the provision of a different and broader content of education for the medical and nursing personnel and the use for their respective specialties of a sufficiently large and varied staff to enable courteous and intelligent investigation and direction through the now labyrinthine procedure of every case.

Since health provides a great, possibly the greatest common denominator, I conceive that the professional or special preparation of all types of health workers should be based on as similar a body of scientific knowledge as possible in order not only that there shall be a complete current of understanding between the workers representing the three essentials—research, education, and practice—*but because constructive functioning in a creative scheme demands of every worker a modicum of each.*

For the nurse, and it is with her function that this paper is especially concerned, I believe that this underlying body of science should be of college grade and should be obtained through the first two years. Following this, she should have not less than two, and better, three years of hospital experience. The value of the hospital as a laboratory cannot be too greatly emphasized. The congregation and variety of cases makes possible in a few months an experience that it would take otherwise years to obtain, but in this bedside experience should be included mental diseases, tuberculosis and diseases of children. Furthermore, definite and comprehensive experience should be given in obstetrics and adequate experience as well as instruction in normal child life. The period of case experience should be of sufficient length and continuity to fix impressions and enable experimentation for the end result.

Of the greatest importance in this scheme of education will be the acceptance by the hospital of the family as its unit of responsibility. The fact that the hospital wards represent but one piece of the machinery in any health program, that the dispensary and the health station with their varied and adequate personnel, and even the home, the occupation and the recreation of the individual case, are part of this project demands that case technique, not less than case experience, shall be included, and these throughout the professional preparation of the nurse. There must be such provision of paid staff for the care of the patients as will enable each student to secure a complete cycle of experience and a reasonably close correlation of theory and practice as expressed in nursing procedures, problems of nutrition, etc.

Requirements for Teaching Staff

The selection, the function, even the daily life of the staff or faculty, are not less important matters for consideration than are the problems relating to the student life. Briefly summarized, the outstanding essentials for this group are as follows:

a. A broad general and professional preparation. Specialization in each and every department or subject. An adjustment of time that will insure the essentials mentioned for a constructive program—research, education and practice—their proportionate part.

b. Opportunity for enlargement of life through a varied experience, such as rotation of executive and teaching experiences, group con-

5. The Principles of Hospital Administration and the Training of Hospital Executives, p. 10.

ferences, exchange experiences with other institutions and organizations.

c. The placing so far as possible of all personnel directing the various phases of the health movement on the executive and teaching staff of the school.

d. Free discussion and participation in determining all questions relating to the organization and administration of the school, its laboratories, the hospitals and, as far as possible, outside organizations with constant emphasis on the inter-relations of all persons and departments concerned in the project.

Finally, the hospital as an exponent of health should provide for its entire personnel sanitary surroundings, adequate and suitable diet, and a properly proportioned daily life from the standpoint of occupation, intellectual development, recreation and rest.

Such a program, such a policy, on the part of the hospital through *the educational force of example* would result in a steady outpouring into the stream of life, workers whose deepened sense of social responsibility not less than their scientific intelligence will permeate the social structure and will accelerate immeasurably the community health and well-being which we are seeking.

THE USE OF WARD HELPERS*

By S. LILLIAN CLAYTON, R.N., Director of Nursing, Philadelphia General Hospital, Philadelphia, Pa.

BEFORE we can discuss the use of ward helpers, we must be sure we understand the meaning of the term. We speak of the ward helper, of the ward maid and of the attendant; but it is important that we do not use these terms interchangeably.

Upon investigation, we find that hospitals have not settled upon any particular outline of duties, hours, salaries or training for these three groups of workers; and because one finds in various institutions representatives of these groups having somewhat similar duties but performing them under different titles, this paper will not be confined to the discussion of the one type of worker —the ward helper.

Three Classes of Workers Defined

For the sake of presenting the subject clearly, we will understand the *ward maid* to be a person employed by the hospital for the purpose of performing general domestic duties in a department. No previous training and no educational standards are required, except such standards of personal integrity and faithfulness to duty as would be desired in a servant wherever employed. The salary and hours should be such as prevail in any given locality. The same reference should be required as would be expected in a home upon the employment of a servant.

The second group of workers, we will term the *ward helpers*. This group should have more intelligence than the first group. No particular educational standards need be required, except that its members speak and read the English language. Their personal appearance and conduct should be such as to be acceptable to the patients. They should receive no training, nor should they have duties that could in any way be interpreted as nursing experience. Their hours and salary should be the same as those given to the ward maids, or perhaps the salary might be somewhat higher. Their position as ward helpers should not be considered as experience qualifying them in any way to serve the public in the care of the sick, whether the sickness be acute, convalescing or chronic.

Among the duties they may perform are: dusting, cleaning utensils, caring for linen, arranging flowers, taking patients to sun parlors, x-ray laboratories, arranging trays, feeding patients, etc.; in other words the duties of these workers are not fixed. The three important points to remember are that the workers are employed as workers, not learners; they receive no instruction; and the result of this experience will in no way prepare them for the care of the sick, nor should they expect it to do so. In order that there be no misunderstanding as to this, thereby causing discontent and friction, they should be thoroughly acquainted with these facts before being employed.

The third group of workers we will for the present, term *attendants*. These women should have completed grammar school; they should be properly qualified physically and personally; they should receive from the hospital maintenance, uniform and a small allowance.

A carefully prepared outline of training both practical and theoretical should be given, covering eight or nine months. At the end of this term, they should receive a certificate and should be ready to leave the hospital. If they remain after the completion of their course they should receive a salary. This salary should be determined by the standard of salaries in a given locality. Hospitals desiring this class of workers and not giving a course for attendants should employ them as stated above.

The content of such a course should be determined by a state board of examiners for registration of nurses. The type of institution in which this training may be given should be determined by state laws and the worker and the patient should be protected by proper legislation.

The use of these groups by any given hospital will be determined by its type of patients, its economic necessity and by its interpretation of its own function in the community. The hospital believing that it has an educational function in the community, therefore desiring the most scientific care for its patients will provide a personnel making such care possible.

Ward maids and ward helpers will be employed in such numbers as to make possible the use of all scientifically trained persons to the best advantage. Persons who by virtue of their high grade of intelligence, personality, training and experience have been employed for these services will be detailed only to the actual care of patients, and to the making and recording of scientific observations. This applies to graduate and to student nurses.

This will be an economical policy also for by so doing, the course of training for the student nurse can be shortened and the graduate nurses employed will be fewer in number, for their time can become concentrated upon the patient, his personal and scientific care. The same hospital will employ trained attendants for such patients as do not need the time of the student nurse or of the graduate nurse. In this age of specialization all of these workers may have a place.

All Three Groups for Chronic Hospitals

In the hospital caring largely for chronic patients, all three groups of workers can be employed with a sufficient number of graduate nurses to make the care of the patients safe. Again, specialization will promote economy in administration, as well as making safe and scientific the care of the patients. The adequate use of these three groups of workers in hospitals is largely a matter of education and of adjustment.

We have spoken briefly of the meaning of these different

*A paper read before the twenty-fourth annual conference of the American Hospital Association, Atlantic City, N. J., Sept. 25-28.

groups of workers and of their uses. We would now speak of two important points to be considered by those who desire to introduce these workers into their organizations.

(1.) What obligations do any such organizations have to these workers?

(2.) What obligations do any such organizations have to the public in making it possible for these new types of workers to assume responsibility for the sick in the community?

In answer to the first question, the organization admitting these groups should know that it can do so without exploitation. In the case of the first two groups, proper working hours, living conditions and fair salaries will prevent any such accusation. It might be added that it will be a great advance in hospital administration when welfare departments are considered a necessity.

Hospitals are increasingly being placed on a business basis; they are becoming intricate in their organization and administration. Because of this, they should consider the welfare of their employes. All too often they are concerned only with the welfare of the patients and of the nursing personnel.

In the case of the third group, the responsibility of the hospital lies in being able to provide the proper working and living conditions; in planning for and carrying into effect the outline of training promised; in providing the proper supervision while this training is being received; in using all its influence to secure proper state laws for the registration and supervision of these workers after graduation, and last but not least in absolutely refusing to prepare such a group of workers unless it can be done in perfect fairness to the group, to the patients and to the public.

In considering what obligation any organization has to the public in making it possible for these new types of workers to assume responsibility for the sick in the community, we must consider:

(1.) Not to employ more helpers in the hospital than are needed in the performance of their particular duties. By doing otherwise, these workers will eventually assume nursing duties, which will lead to a misrepresentation of themselves to the community, and later render them dangerous factors to public health. The institution must not make it possible for them to imitate nursing procedures which they are incapable of performing scientifically, resulting thereby in reducing the patients' faith in the hospital.

(2.) In the case of the patient in the hospital, no one, regardless of his financial standing in the community should be subjected to the care of this group if critically ill, for there will exist a lack of confidence on the part of the patients, and their well-being may be seriously affected by the lack of necessary intelligent care.

(3.) If attendants are trained, the hospital should consider it necessary to have as satisfactory a reputation for its attendant school as it would for its nurses' school.

(4.) Hospitals should refuse to train attendants until the necessary legislation has gone into effect, making it impossible for the medical profession and the public to employ them under any misrepresentation as to their preparation.

The trained attendant is a necessity, but if she is really to perform her function in society, the following principles must be adhered to:

The proper course of training must be decided upon as to content and duration.

The proper provision must be made for her living and training.

The proper laws must be made as to the conditions under which she shall practice.

This type of worker has been tried in many hospitals, private homes and public health organizations. There is no question as to her value, but this value has been limited because the principles, as stated above had not been observed.

This brings us to the recent report made by the committee appointed by the Rockefeller Foundation to make a study of the nursing situation in this country. I wish to refer to that part of it which considers the "field for a subsidiary type of nursing service."

In this section we find that private physicians, health administrators and hospitals need two types of nursing service, emphasizing the fact that these two types should be provided, according to the type of illness and not on economic grounds.

The latter "economic grounds" is questioned by this committee, for it has been found that the margin between the average annual income of the private duty nurse and that of the domestic servant, is not so great as to permit the existence of an intermediate grade on a salary level very much below that of the present registered nurse. This committee recommends these workers for the mild or chronic and convalescent case. It further reminds us that of the 300,000 male and female nurses in the United States, more than one-half are of grades below the standard of the graduate nurse. This class of workers is a real fact and it fills a real need.

The nursing profession has discharged a fundamental duty to the public in stimulating the development of registration laws, which define and delimit practice of the profession and which protect the community against fraud and exploitation by those who collect fees and assume responsibilities to which their qualifications do not entitle them.

In addition to the registration of the trained nurse it is essential that the lower grade of nursing service should be defined and registered. The committee recommends that the name of this group of workers be *nursing aide* as it meets the need for clear differentiation while providing the subsidiary worker with a suitable name. With the two distinct grades of service available, the individual physician would be responsible for the choice of a trained nurse or a nursing aide in a given instance.

The public can only be safeguarded in these matters by state legislation for the definition and license qualifications of each nurse or nursing aide furnished.

The committee's conclusion of the matter is "that steps should be taken through state legislation for the definition and licensing of a subsidiary grade of nursing service, the subsidiary type of worker to serve under practicing physicians in the care of mild and chronic illness and convalescence, and possibly to assist under the direction of the trained nurse by certain phases of hospital and visiting nursing."†

In conclusion, we beg to state that we believe the ward helper and the nursing aide or attendant can best be used in our effort to carry out the ideals of adequate nursing care for all the sick public, under conditions mentioned earlier in this paper and voiced in a different way by the Rockefeller Committee. If the American Hospital Association and the nursing organizations unite their efforts and have the same objective for the use of these workers, we believe that much of our present problem as to how to supply adequate care for the sick will be solved.

†The above statements referring to the Rockefeller report were taken from Miss Goldmark's report of the work of that committee.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
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THE RELATION OF THE HOSPITAL AND THE CHILD: A SUGGESTED SOLUTION*

BY FRANK HOWARD RICHARDSON, M.D., CHILDREN'S DEPARTMENT, BROOKLYN HOSPITAL, BROOKLYN, N. Y.

IN THIS discussion, I am more concerned with minimizing the time to be spent by the child within the hospital, than in considering how he shall be fed while he is there. In other words, the needs of the hospital as related to the child must constitute our sole criterion in considering every aspect of our problem.

It is only fair to face the fact that the children's hospital and the children's ward, as constituted in most places today, are really on trial, and are called upon by thinking folk everywhere to justify their existence, or at least their existence under ordinary conditions as we meet with them.

Has Hospitalized Child a Fair Deal?

The ideal relation existing between the hospital and the child has long been a subject for keen debate. It used to be generally accepted that there was nothing better for any sick child, whether rich or poor and of whatever age, than to be subjected to the regular, steadying regimen of the life of the hospital ward, with its carefully regulated diet, its freedom from excitement, and its cleanliness and perfect sanitation. It took some of the horrifying statistics of some of the big institutions which care for children, with their 100 per cent mortality rate for infants who stayed long enough in their wards, to jolt us out of this complaisant mood and to make us wonder whether such mortality records could coexist with a fair deal to the hospitalized child, no matter how beautifully white the walls and the beds of such wards might be. Such figures as these, and they can be matched without much trouble today wherever infants are brought together in wards and kept for any length of time, cannot be gainsaid; it is admitted by us all that the bottle fed baby fares wretchedly even in the best of wards.

And yet not every pediatrician is willing to go so far as does Chapin, for instance, in feeling that every institution for the care of children, except those providing only the most transient and transitory care, is a curse to the child. Of course, "hospitalism" as seen in the wan, listless infant who refuses to thrive on any mixture, no matter how well-adapted theoretically to his needs, or as seen in the "good" child of the oldtime orphan asylum, with his uniform clothing, his lockstep play, and his brooding air of detachment and lack of interest in life, is going to find no defenders today among thinking people, especially among such a gathering as this. But is even the possibility, much less the probability, of such a commonly observed phenomenon, for instance, as cross infection, not enough to render the admission of a child to a hospital ward at least a very real hazard to which we must subject that child only after determining that the gain is far in excess of the possible harm? As serious students of the hospital problem in all its bearings today, it behooves us seriously to consider and weigh the "pros" against the "cons"; to evaluate both, justly, in order to arrive at a conclusion which shall be satisfactory to us as hospital specialists and as human beings.

First, then, the "pros," which are not only manifold but plainly manifest, and seem to admit of no denying. Certain conditions one thinks of offhand: such are surgical procedures practically impossible of accomplishment outside of hospital walls; the nursing problem with its excessive financial drain upon the purses of even the more than moderately well-to-do especially in such long-drawn-out cases as typhoid, or some of the surgical infections; the exigencies of such a treacherous, fulminant disease as pneumonia with its demands for constant attendance and constant alertness on the part of both doctors and nurses; the sudden deprivation of parents, either by death or by disease or accident, with its consequent temporary "boarding" of the well child in the ward; all of these seem to constitute almost insuperable reasons for the hospitalization of children (using the term here in its original and best sense).

The "contras" have been hinted at above. The appalling death rates of infants in even the best-regulated of infant wards, if they remain there for any length of time; "hospitalism" in its worst sense, a condition that no clinician or experienced nurse needs or cares to have called to mind with its picture of unavoidable and early dissolution stamped on the tiny faces of its victims; cross infection, that bane of everyone who deals with children in institutions; the frequency with which a child well on entering the institution (the so-called "boarder") becomes a sick child before leaving; the marked reluctance of parents of any social or economic status to give up the care of their children unless absolutely unavoidable; the usual extreme terror of the average child at the mere

*Read before the section of dietetics at the twenty-fourth annual conference of the American Hospital Association, Sept. 25-28.

mention of the separation involved in hospital admission; the mental effect upon the child of the sights and sounds of a hospital, with the inevitable resultant psychic trauma and scar; the unnecessary expense of detailing in the hospital for long periods of time with the well known high per diem expenditure, such cases as long-drawn out orthopedics, interval or terminal convalescents; and the consequent occupation of beds that should be available for really acute cases—all these constitute the other side of a picture that at times seems to present an overwhelming case for the negative, too depressing, not to say uneconomic, to be allowed to continue.

Finds Way Out in Out-Patient Department

What then are we to do? What can be suggested as a possible solution of the problem? Can we fairly and truly say that the hospital treatment of children is out-of-date, as Chapin virtually does; and lives out his conclusion in the establishment of his wonderful system of Speedwell Orphanages, where the children and infants are boarded or adopted out, with only the shortest possible detention in hospital on the way? Or shall we say that the children's ward, as ordinarily conducted, has been with us always and must always continue as it is? Or is there perchance some middle ground which we can find, and on this erect our structure?

My own belief is that we have ready to our hand, although so far not very widely utilized to its fullest extent, an agency that offers the ideal solution of this very real hospital problem. This agency is that properly conceived and properly run out-patient department, with its logical appendage, the nutrition or health class. For such a department is nothing more or less than an amplification of the children's ward, with a multiplication of its opportunities for service; which takes over every conceivable phase and function of the children's ward except such as absolutely demand the facilities offered by the ward, and not available elsewhere.

I am, of course, speaking here of the out-patient department which is staffed by the identical men who compose the intramural staff of the children's department, and which functions as an integral part of the pediatric service, with a single record that passes freely with the patient from clinic to ward, and vice versa, as circumstances vary and inside treatment becomes imperative or ceases to become so, and outside care becomes possible. I am, of course, barring out from discussion the more usual conception of a children's clinic—as a nuisance imposed upon the juniors of the service, to be pushed by them, if possible, upon the shoulders of young practitioners not connected with the hospital staff who do not know any better than to be thus imposed upon.

Under such a perfectly coordinated system as we are supposing, supplemented by the cooperation of the up-to-date social service department, every case is carefully and fully studied while at home, and every appropriate diagnostic aid is applied before the child is asked or allowed to enter the hospital. Many an actively, even desperately, ill child may never need ward care at all. If, however, a hospital sojourn proves unavoidable, it is reduced to its shortest possible extent for it does not begin until the latest possible moment and is terminated the very moment the child has recovered sufficiently to be carried home in its parents' arms and brought back to the clinic for follow-up work. There is no break in continuity of attendance as the medical attendants are the same outside as in the ward; the visiting nurse takes over the functions of the ward nurse; and special diet, where needed, is directed, supervised, and if necessary provided, by the social service department. Return visits are secured as a matter of course; for even quite seriously ill pediatric cases may be handled as ambulant cases, both before and after their stay in the ward, in the sense that they can safely and easily be carried to the clinic, whereas equally ill adult patients could not be so handled. The fact that the same doctors who made the first contact with the case, studied it before its admission, and carried it through its sojourn in the ward, are the ones who will go on with the conduct in the out-patient department, render such return visits almost a matter of course.

That most useful appanage of the out-patient department, the nutrition class, carries all these advantages to the nth power. For here we already have in operation the nearest approach to the ideal of preventive medicine that has so far been made available for general hospital use in a community. Here we have at work the machinery for giving the child, before acute illness comes upon him, the complete, all-round, searching examination that the life extension institutes have rendered available for adults—the inter-departmental liaison, if you will, that alone can adequately provide an examination so much wider in its scope than medical pediatrics alone is prepared to give. Here we have, too, the confidence in the doctors born of intimate friendly acquaintance with them in time of health; the familiarity with the hospital, the nurses, the dietitian, the social service workers and volunteer aides, growing out of the happy times spent at the weekly sessions of the nutrition class, with its games, its fun, and its frolics; and the realization, early impressed upon every child and every parent, that immediate treatment of every symptom, whether serious or trivial, is the only safe and sensible course. All these conditions combine to make an ideal patient, in an ideal frame of mind, whenever entrance into the hospital does become necessary.

It goes without saying that such an ideal milieu for the hospital patient exists only in the hospital whose out-patient, pediatric department is an integral part of its children's service, such as has been sketched above, with identical staff, single record, and absolute ease of transfer from out-patient to in-patient service, or vice versa, as occasion may require. How simple and rational such a condition of affairs seems; and yet how rarely is it to be met with in actual hospital practice! I venture to go to the logical limit implied by what has gone before and say that the hospital which lacks such a coordinated children's department is wasting the money entrusted to it by its donors, is depriving needy children of bed space that they should have, and has no right to attempt to minister to children at all!

Urges Use of Certified Milk for Babies

I cannot close this paper without saying just a word as to the modern trend in the feeding of infants on the part of the best pediatricians. Whereas there was a time not so very far back when doctor vied with doctor in the creation of milk formulas that exhausted the resources of the higher mathematics to comprehend, much less to prepare, there has of recent years been a most healthy reaction in the direction of what has come to be known as "simple dilutions." Hand in hand with this simplification of what is done with milk *after* it comes to our hands, or perhaps lagging a step or two behind, has come a realization that perhaps it is even more important to know and to control what happens to this highly perishable and most easily contaminated product *before* ever it comes into the diet kitchen at all. In other words, whereas it may be beyond dispute that "pigs is pigs," it

certainly is not equally true that "milk is milk," at least in our vast metropolitan areas today, if by "milk" we mean a food that is clean and decent enough for our babies. It must come to be realized on a far greater scale than has so far been the case, that the only milk fit to be given to an infant or a child, inside the hospital or out, is pure, fresh, unaltered, uncontaminated, sweet-smelling and sweet-tasting cow's milk; and quite as important is it to realize, I say it advisedly, that the only milk that conforms to these simple and minimum requirements, in these huge cities of ours today, is certified milk. I would urge you as dietitians, who would be amazed and scandalized if you were asked to prepare for your patients tainted meat, cold storage poultry, third class eggs, or dirty or wormy cereals, to take equally high ground, on any and all occasions when the opportunity comes to you, with regard to the milk that you are asked to modify for the little ones who look to you for the means of subsistence, and to urge upon your superintendents the desirability of procuring certified milk for the children's diet kitchen.

NEWS ITEMS

Miss Ruby Odell has recently gone to Rochester General Hospital as dietitian. Miss Odell has been at the Corning Hospital, Corning, N. Y. since graduating at Cornell in 1921.

Miss Mary Louise Shaw is at St. Mark's Hospital, New York, N. Y., in charge of the diet kitchen and teaching of dietetics.

Miss Irene Willson gave up her work at Akron City Hospital to go with Mr. H. G. Yearick to the Homeopathic Hospital, Pittsburgh, Pa. Miss Willson was secretary of the Ohio State Association of Dietitians. Miss Mayme Lewis succeeds Miss Willson at Akron City Hospital.

Other dietitians who have recently assumed charge of departments in new places are:

Miss Nell Dahl in the Fairview Hospital, Minneapolis.

Miss Helen Clarke in the University Hospital, Columbus, Ohio.

Miss Margaret Anderson in the Trumbull Hospital, Brookline, Mass.

COMBATTING THE LOUSE IN TYPHUS HOSPITALS

The humble louse, the annoying activities of which have been directly responsible for millions of cases of typhus and thousands of deaths in post-war Europe, is the subject of an interesting report just issued by American Red Cross headquarters in Paris. The report describes the anti-typhus work done by the Red Cross during a very severe epidemic of typhus at Cattaro, Dalmatia, resulting in nearly 40 per cent of deaths among Russian refugee patients there. The Red Cross sent a special corps of typhus specialists to the scene, under Dr. C. C. Yount of Pittsburgh and Dr. J. R. Ransom of Cleburne, Texas, and the epidemic was finally stamped out.

An interesting part of Dr. Ransom's report is devoted to describing the precautions taken to protect doctors and nurses engaged in the anti-typhus work.

"Protection of the personnel in the hospitals depends mainly on the efficiency of the disinfecting squad," writes Dr. Ransom. "Typhus is not directly infectious, it can only be carried by the medium of the louse. Therefore if patients are properly disinfected there is absolutely no danger to the hospital personnel. In this respect typhus is similar to malaria. There is no danger from a patient with malaria, nor is there any danger from typhus.

"At our stations in Milina, on Cattaro Bay, every refugee was put through a delouser. All the hair was clipped close, and the patient was scrubbed thoroughly with soap and hot running water. The body was annointed with kerosene or coal-oil. Clean pajamas were placed on the patient and he was wrapped in a clean blanket and transferred to his bed in the hospital. His clothes were put through a pressure steam sterilizer, and furs were put through a sulphur bath. In this way only louse-free patients arrived at the hospital.

"Any person finding a louse on a patient or on the clothing of the personnel was required to report this immediately to the physician in charge of the hospital or to the chief nurse, at which time special steps were taken to discover from what source the louse came.

"It is seldom necessary for physicians or nurses to expose themselves by handling louse-infected patients and articles of clothing, as there are always present persons who have had typhus, who can handle typhus patients and their clothing. The work of the physician and the nurse should be directing and not handling patients or articles of clothing. Too many overenthusiastic persons think they must demonstrate the fact that they are not afraid of typhus or of work. These people are penny wise and pound foolish. They are sure to be infected sooner or later and then their work must be done by someone else.

"In the field, where physicians and nurses are required to come in close contact with infected cases, it is important that they be provided with a combination undersuit of closely woven white cotton, with stockings, long sleeves and a high collar. This garment should be worn just over the underclothing. Rubber boots or high laced boots must be worn to prevent louse from crawling up from the floor.

"Woolens should be avoided, as the louse clings to such garments. Cotton and silk are best. I prefer a trench-coat as an outer garment. The material is of such texture that the louse cannot cling to it and is easily shaken off.

"At the completion of the day's work the outer garment should be taken off, shaken and hung up where it will not come in contact with other articles of clothing. A bath should be taken every night and all the clothing changed. To finish the bath the body should be sponged with a soapy water made of germicidal soap which should not be washed off. I have been using this soap ever since I began to work in typhus areas; and as I have caught several lice on my body and have never been bitten by one, I am convinced that the louse will not bite the skin recently washed with such a soap.

"One thing that must be remembered is that typhus is not as frequently conveyed by the bite of the louse as it is from the crushing of the louse and smearing of the body contents over the abrased skin. The natural instinct when one feels a bite is to scratch or rub the area through the clothes. This is just what must not be done, because this crushes the louse and smears its body contents. In Milina we carried a bottle of chloroform, and when we suspected the presence of a louse on the body or we felt a nibble, we simply covered the spot with the open mouth of the bottle and inverted it so as to saturate the clothes over the area with chloroform. In this way the louse, if present, was killed and we avoided the danger involved in crushing by scratching or rubbing. Not only does the chloroform kill the louse, but it neutralizes the virus in the bite."

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

TWO CINCINNATI HOSPITALS ARE CHAMPIONS OF ELECTRIC COOKING

By WALTER T. WILLIAMS, Cincinnati, Ohio.

JUDGING from the experience of two hospitals in Cincinnati, the use of large electric ranges and ovens is altogether satisfactory and offers many advantages. In the kitchen of the Deaconess Hospital, of which institution Rev. A. G. Lohmann is superintendent, all of the cooking is done on a large electric range, which has as an adjunct a large electric steam table or warmer. Both of these units are shown by accompanying illustrations. At the time of this writing they have been in use about six months, and therefore it may be stated that they have had a thorough and practical test.

The range is of the Edison heavy-duty type, with four enclosed surface, or top, units and two oven units. When the current is turned on to full capacity, four kilowatts per hour are used by each of the former and three kilowatts per hour are used by the latter, making the total consumption when all units are turned on, twenty-two kilowatts per hour.

This electric range used in the Deaconess Hospital, Cincinnati, for several months has given general satisfaction and is regarded as economical.

The actual current consumption of the range, however, is much less than this, for the maximum current consumption is only used for a short time when the preparation of a meal is begun. As the stove and the food heat up, the amount of current used is gradually reduced. For instance, as soon as the contents of a vessel reaches the boiling point, the switch controlling the unit on which it stands is brought back to "medium" and later to "low," which maintains a sufficiently high temperature.

In case of an oven, whether it is a part of the range or a separate one, the economy is still greater. This is because the oven, like a "fireless cooker," is so well insulated against radiation that the heat cannot escape, and when it and its contents become heated to the desired temperature the electricity may be turned off and the cooking will continue for a long time.

Each of the six heating units of the range is controlled by a three-heat switch, and this affords a diversified temperature, making each unit independent of the others. These stops are respectively marked "High," "Medium" and "Low." At medium heat the current consumption is one-half and at low heat it is one-fourth.

The electric steam table is not needed at all times, but it has been found to be very useful when an unusual number of persons are to be served, on such occasions as meetings of the board, meetings of committees, and entertainment of large numbers of guests on special occasions. The maximum current demand of the steam table is small, it having two units of three kilowatt consumption each, or six kilowatts in all.

The combined current consumption of the range and the steam table, as determined by a survey by a careful and reliable electrical engineer and as checked up by an expert of the power company, averages 4,000 kilowatts per month. While under local conditions this current cost is about $13 more per month than the fuel cost of the gas range which formerly was used, this excess of cost is more than offset by other matters. For one thing, the shrinkage of meats that are prepared in the oven is greatly reduced, and while no exact figures are available, it seems that this alone should throw the balance in favor of the electric range. With other fuels the shrinkage of meats cooked in an oven has been found to be 30 per cent, but with an electric oven the shrinkage is only 13 per cent, leaving a saving of 17 per cent in favor of the electric device.

The floor space occupied by the electric range is only 39 by 48 inches, while a gas or coal range of the same capacity usually takes up considerably more room. On the top of the electric range there are no lids and openings, as

is the case with gas and coal ranges, but the vessels are set on the top over the heating units. For this reason the cooking utensils are never blackened with soot; there is no flame to touch them. This feature also effects a saving, for it reduces the kitchen labor; with a gas or coal range it takes more than a little time to remove the soot and coal-tar deposits with which the flame coats the bottom of each vessel. While this economy cannot be demonstrated in dollars and cents, it nevertheless is self-apparent.

The hospital's chef is very enthusiastic about his electric range for several reasons. With the gas range he could not maintain an even temperature, for the pressure of the gas was not regular. Sometimes, in cold weather, the gas supply reached the vanishing point, as natural gas, the only kind available, has a way of doing. With the electric range the chef is able to maintain an absolutely even temperature, at any necessary degree and for any length of time, which to him is a very important thing. Being well insulated isothermally, the range gives off a minimum amount of heat, which adds to the comfort of the kitchen.

The Deaconess Hospital has accommodations for eighty patients and there are forty-five nurses and eighteen miscellaneous employes, so when it is filled there are about 143 persons to be provided for. The range easily takes care of the cooking for all, and with the assistance of the steam table a much larger number can be taken care of without trouble. In fact, I was assured that the outfit easily could prepare three meals a day for eight hundred persons, and that this would require but a small amount of additional current.

Electric Oven Costs Hospital Nothing

The electric bake oven seems to be an entirely satisfactory and extremely economical apparatus. One of the illustrations herewith shows a large portable electric bake oven. This is located in another hospital in Cincinnati, the Good Samaritan, of which Sister Rose Alexius is superintendent. This large oven takes care of all of the miscellaneous baking, such as rolls and pastry, of this large hospital, which has beds for 218 patients and a resident personnel of 185 persons, making 403 to provide for when the institution is filled.

It literally costs nothing to supply the current to this oven. On the contrary, the hospital reduced its total expense for electricity when it installed the oven, thereby getting a revenue from it. The current used by the hospital now costs about $7 per month less than it cost before the range was installed, because by increasing its electric consumption the institution earned a decreased rate per kilowatt, so now it gets a greater amount of electricity than before for a decreased amount of money.

The electric steam table used in the Deaconess Hospital, Cincinnati, is an adjunct to the electric range. It has been found to be most convenient and its current consumption is very small.

This oven occupies a floor space of 45 by 36 inches, the latter dimension being from front to back, and it is 70 inches high. It is in one section, with three baking compartments, each 8 inches high, 27 inches deep and 38 inches wide, with a heating unit under each and a fourth unit over the top compartment. The maximum current consumption is nine kilowatts. Each of the four units has a three-heat control, with "Full," "Medium" and "Low" indicated, the same as on the range.

An electric bake oven is used in the Good Samaritan Hospital of Cincinnati. The institution's total bill for electricity was less after the oven was installed than it was put in.

Each compartment has a thermostatic thermometer at its side, next to the heat control, and this gives a true reading of the temperature within, thereby taking all guess-work out of the baking operation. As soon as the baker has ascertained the temperature which is necessary for a given article he can so regulate his oven as to be sure that his product always will be the same, as far as the baking is concerned.

An electric oven, if properly constructed, has a very low current consumption. As soon as the oven and its contents reach the necessary temperature the current may be reduced, or it may in many cases be turned off altogether. This is because the oven is well insulated isothermally; as practically no heat is lost through radiation, it becomes a "fireless cooker" and baking continues for a long period, from stored heat.

The foregoing brings up some important matters that should be considered in connection with the installation of electric cooking apparatus. In almost every city there is a sliding scale which automatically reduces the price per kilowatt of electricity as the consumption of current increases. When the Deaconess Hospital installed its electric range and steam table, its increased consumption of electricity automatically brought the rate from six cents per kilowatt down to three and one-third cents per kilowatt. Likewise, as has been explained, the current rate was reduced to the Good Samaritan Hospital, and the result was that after it had installed its electric bake oven the institution's electric bill was less than before.

Gas, it should be remembered, varies as to heat units. Natural gas, which is the only kind supplied in Cincinnati, has many more heat units per thousand cubic feet than are apt to be found in the manufactured gas which is supplied in most cities. Besides this, one natural gas may contain more heat units than another. Hence, in making calculations as to the comparative cost of gas and electricity one should consider the cost of gas by heat units, not merely as to thousands of cubic feet.

Some Advantages of Electric Cooking

Some of the advantages offered by the use of electric cooking apparatus may be summarized as follows: The danger of burning or scorching is negligible—one might almost say absent. The fire risk is reduced, for there is

no danger of a gas explosion and no matches are used. No unsightly piping is necessary to carry off the gases and fumes, and there is no necessity of cleaning pipes in which soot has collected. An even temperature may be maintained indefinitely and in case of an oven there is no danger of spoiling the result by opening the door. There is very little radiation from an electric range and there is none whatever from an electric oven.

Other advantages depend on the cooking equipment of the hospital and its requirements. For instance, the Good Samaritan Hospital has no electric range, but some of the baking which ordinarily would be done in the oven of a range is done in its electric bake oven. This includes the baking of chickens, potatoes and many other things; even rice is cooked in the electric bake oven.

The heating elements for the surface units of the range last several thousand hours, are not expensive to renew and may be replaced in five minutes. The heating units for both types of ovens are so constructed as to last indefinitely. There are no stove lids to warp, no gas burners to adjust and clean and no linings and small parts to replace at intervals.

It may be well to state in conclusion, for the benefit of any who may want to make comparisons, that from a competitive fuel-cost standpoint, conditions here are much less favorable to electric cooking than they are in most other cities. Local conditions should be considered in all calculations.

NEW SALINE APPARATUS MEETS REQUIREMENTS

By A. B. DENISON, M.D., Assistant Director, Lakeside Hospital, Cleveland, Ohio.

IT IS altogether probable that the production of normal saline solution is a problem that faces most hospitals, particularly those with larger surgical services. The methods most commonly used in making saline are certainly far from satisfactory in many respects. They are mostly slow and very inaccurate and offer a maximum of opportunity for contamination of the saline. In this hospital the problem reached such a magnitude that we were forced to devise a method whereby we could make better, more accurate, and more uniform saline in a shorter period of time. In so doing we kept in mind the general basic requirements of a satisfactory salt solution for subcutaneous or intravenous use. These requirements are:

1. Sterility. It must be absolutely sterile.
2. Freedom from sediment or cloudiness.
3. Freedom from any element other than those intended, viz: salt and water.
4. Uniformity. Every flask of saline must be of exactly the same concentration and this concentration must be fixed and known.

The attachment we have developed meets all of these requirements perfectly and at the same time shortens the time required most strikingly. The speed of this process is particularly striking when compared with the fractional sterilization method so commonly in use.

In discussing the apparatus it may be well first to refer to the illustration showing its construction. It is seen first that the apparatus is an attachment to be added to any ordinary water sterilizer with very little alteration. The condenser is so arranged as to deliver the water distilled from the first tank ("A" boiler) to the second distilled water tank, "B." A steam by-pass "F" is taken from the upper part of the distilled water tank to provide for sterilizing the saline attachment.

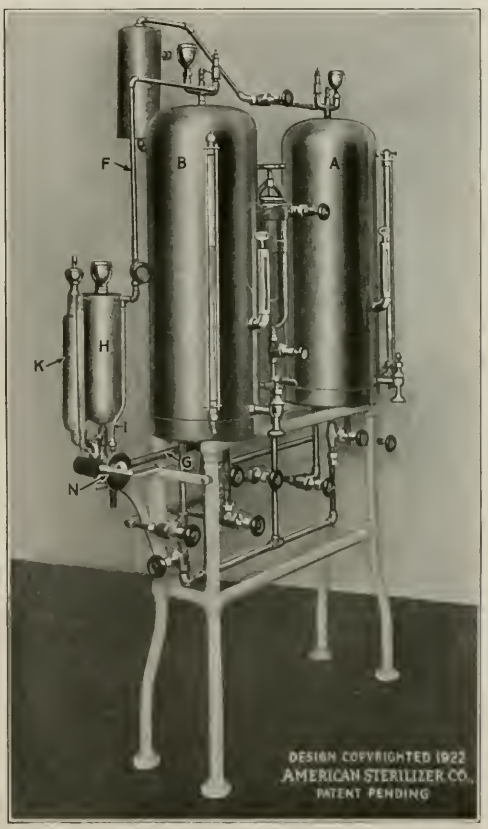


Diagram of Saline Apparatus

The saline apparatus consists of three main parts: the measuring valve, the saline storage tank and the mixing chamber. The measuring valve is graduated to hold exactly 80cc of liquid at room temperature. It is provided with ports so arranged in its circumference that in the various positions as indicated by the dial "N," the proper ports are open to carry out the various steps of the operation. At "close" all are closed. At "salt" the ports leading to the tank "H" and the air release pipe "I" only, are open. Since the pipe "I" is lead from the highest part of the measuring valve, there is no air pocket formed and the measuring valve is completely filled with the salt solution from the saline storage tank "H." So, when the measuring valve is turned so as to close these ports, exactly 80cc of the strong salt solution has been "bitten off." When the indicator is moved around to "mix," ports are brought open opposite the pipe "G" leading from the distilled water storage and opposite the pipe leading to the mixing chamber "K." Distilled water then flows

from the large tank through the measuring valve until the mixing chamber is full. A float valve prevents overflow. This mixing chamber has a capacity of exactly 920cc, making the total volume of this chamber and the measuring valve exactly 1000cc.

When the indicator is turned still further around to "draw off" all ports are closed except the ones opposite the mixing chamber and the outlet. The mixing chamber and the measuring valve are thus completely drained, delivering exactly 1000cc of saline. The concentration of the resulting salt solution naturally is dependent upon the concentration of the strong salt solution in the saline storage tank, "H." If this strong solution is 10 per cent the resultant saline solution will be 0.8 per cent. So, if it is desired to make a solution of a concentration different from 0.8 per cent the strong salt solution must be correspondingly changed from 10 per cent.

Of course it is realized that the description of this piece of apparatus is very fragmentary and sketchy and omits many essential details but it is hoped that it may serve to give a general idea of how the apparatus is made and how it works. We have found it extremely satisfactory in every way. The distilling apparatus works very rapidly and efficiently and after the distilled water is collected, the saline can be made very rapidly indeed; in fact it requires about nineteen seconds to carry out a complete cycle of measuring the strong salt, measuring the distilled water, mixing and drawing off the one liter of saline solution.

We have shown by repeated experiment that the saline solution is perfectly sterile, thus proving the possibility of dispensing with the old time-consuming method of fractional sterilization. The saline solution is perfectly clear and free from sediment or cloudiness. Repeated analyses have failed to show any contamination from any source.

No filtering of the solution is needed, thus removing another possible source of material contamination. Further, the saline produced is uniform in concentration, every sample taken being practically the same. The apparatus is practically foolproof and reduces greatly the points where error may creep in.

It is perfectly obvious that the possibility of variation of concentration is greatly reduced since it is necessary to make up accurately but one solution instead of attempting to measure each individual flask of saline accurately. This apparatus is so built that once the strong solution is accurately made up, all saline from this solution will be the same in concentration. The fact that the apparatus is a closed system preventing contamination insures the absolute sterility of the final solution.

The apparatus was on exhibit at the convention of the American Hospital Association in September.

THE ROTHROCK DELIVERY BED

By K. H. Van Norman, M.D., Superintendent, The Charles T. Miller Hospital, Inc., St. Paul, Minn.

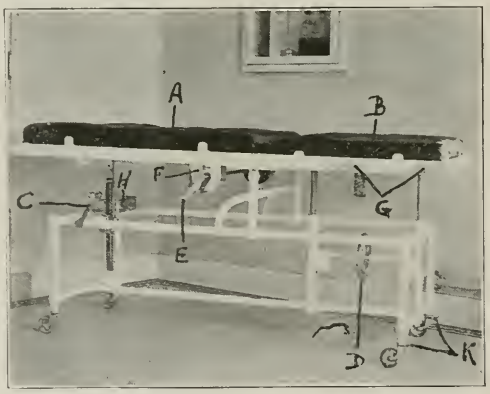
Dr. J. L. Rothrock, in charge of the obstetrical and gynecological services of the Miller Hospital, St. Paul, has devised and recently has had manufactured a delivery bed which incorporates so many long felt wants that it seems desirable to present its advantages to the hospital world.

The chief objective sought in working out this design was to produce a practical delivery bed which would be comfortable for the patient, simple in construction, easy of manipulation and on which the position of the patient could be quickly changed to the usual positions desirable in normal or instrumental deliveries.

1. The bed is of very simple design and can be easily operated, with the patient upon it, by one person.

2. It offers unsurpassed facilities for the preparation of the patient with the minimum amount of soiling of linen.

3. The position of the patient recommended for normal delivery makes possible the carrying out of a more consistent aseptic technique than is possible with any hitherto devised plan of management. With the buttocks brought well down to the lower end of the upper section and with the lower section of the bed slightly lowered, the discharges from the patient towards the close of the second stage of labor may be received in a basin and the field may thus be kept reasonably clean.



The Rothrock table in ordinary position showing:
a. Upper section.
b. Lower section.
c. Crank for raising or lowering head of bed.
d. Wheel for lowering or raising lower section.
e. Crank for rolling upper section to foot of bed (over lower section).
f. "T" shaped lock for locking rolling gear.
g. Sockets for foot rests.
h. Tray for ether masks.
k. Brakes on casters.

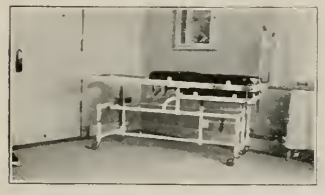
4. This position of the bed facilitates delivery of the shoulders after the head is born as it enables one to make traction downwards and backwards.

5. The lower section of the bed, when slightly lowered, affords a convenient platform on which the new born infant may be placed until the cord is tied and severed.

6. Furthermore, this position of the bed during the third stage of labor permits placing a basin under the patient to receive the blood and placenta, thus preventing the soiling of the bed.

7. It also permits inspection of the perineum and facilitates the repair of lacerations without bringing the patient to the foot of the bed.

8. The foot-rests are of a new and original design with flexible joints adapting themselves to the comfort of the patient and the foot may be securely strapped on so that



Upper section rolled down over lowered lower section.

in anesthesia the patient cannot disengage her feet.

9. In case of post partum hemorrhage or sudden collapse, the head of the patient may be lowered without changing the position of the patient on the bed.

The bed has the following dimensions:

Length over all, 74 inches; upper section, 42½ inches; lower section, 28½ inches.

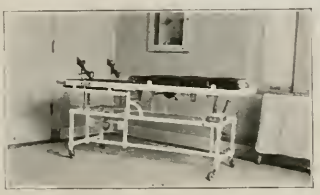


Table in position for reception of patient, with end section lowered.

Bed with head lowered.

Width—outside, 28 inches; inside, 26 inches.

Height—to top of frame, 32 inches; to top of cushion, 35 inches.

Cushion — 3 inches thick.

The table has been in use for the past three months and it came up to every expectation. It was manufactured by a well known firm of the Middle West.

Bed with head raised.

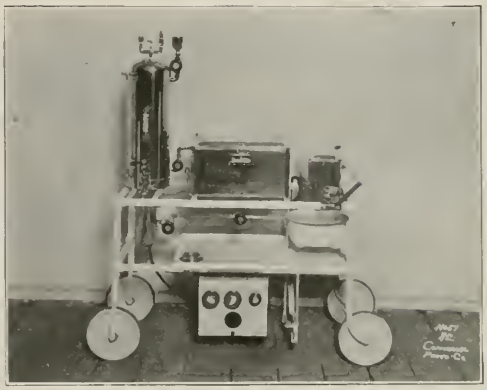
A PORTABLE ELECTRIC STERILIZING AND HOT DRESSING OUTFIT

One of the interesting innovations in hospital equipment which was introduced to the field at the Atlantic City conference of the American Hospital Association was a new portable electric sterilizing and dressing outfit.

The application of this equipment in the modern institution is readily apparent to an administrator. It permits of hot sterile dressings being applied at the bedside of the patient and gives a certainty of asepsis and a convenience that has hitherto been lacking.

The outfit is mounted on a substantial tubular steel frame finished in white enamel and supplied with four large rubber-tired wheels, two of which are swiveled.

Electric heating units are supplied for the various parts of the outfit and electric connections can be readily made in the ward or private room. The outfit consists of a four-gallon water sterilizer or reservoir, electrically heated; a hot dressing container 9″ deep, 12″ wide and 18″ long, and an instrument sterilizer 5″ deep, 6″ wide and 16″ long.



Portable sterilizing and hot dressing outfit

The hot dressing container is fitted with a spray coil and a specially designed steam trap so arranged as to insure thorough saturation of the dressing with uniform distribution of heat throughout the chamber. The foot control raises and lowers the cover of this container, while a hand control regulates the cover and also raises the tray of the instrument sterilizer.

Additional equipment includes a swinging soiled bandage pan and an instrument receptacle located in the shelf of the frame.

The outfit is supplied with electric heaters fully submerged and connected with cords to multiple heat switches, provided with separate fuses for each switch. The water tank heater is the multiple unit type, and the heaters for the hot dressing container and instrument sterilizer are of the automatic cut-out type, thermostatically controlled.

As indicative of the care exercised in planning this outfit attention is called to the special bell-protected draw-off cock from the water container, the air filtering vacuum valve, and the thermometer indicating both temperature and pressure.

HOSPITAL TRUSTEES AWARD TWO PRIZES IN WARREN TRIENNIAL

Because of the difficulty in determining the relative merits of two essays submitted for the Warren Triennial Prize of which the general executive committee of the Massachusetts General Hospital, Boston, is the arbitrator, two prizes were awarded this year.

At a meeting of the trustees of the Massachusetts General Hospital held October 13, it was decided that two prizes instead of one be awarded this year, the first prize to be $500 and the second prize to be $250; the award of the second prize this year, however, not to be taken as establishing a precedent.

There were twenty-one essays submitted, the contestants being from the following countries: Poland, Germany, Italy, Hungary, England and United States.

The first prize went to the essay, "The Circulation in the Mammalian Bone-Marrow," written by Cecil K. Drinker, M.D., Katherine M. Drinker, M.D., and Charles C. Lund, M.D., all of Boston.

A second prize was awarded to the essay, "The Effect of X-Rays on the Nuclear Division," written by James Mott Mvaor, M.D., Union College, Schenectady, New York.

ECONOMIES IN THE BOILER ROOM

THAT superintendent is indeed fortunate who does not find the problem of the boiler room and power house a more or less constant worry and anxiety. The fact that this is so frequently the case is due in some measure at least to a lack of definite knowledge of boiler room problems on the part of the average hospital executive. There is probably no other department of the hospital that requires more careful attention in order to prevent the constant accruance of undue waste and expense.

The same problems confront every hospital superintendent, no matter what the size of his institution or whether the so-called boiler room includes merely an ordinary heating plant or whether it is complicated by a range of steam boilers, electric generators and other power equipment. It is a recognized fact that each year thousands of dollars needlessly go up in smoke through the flues of the boiler room. A large part of this waste is preventable and simple precautions will mean a definite saving to the hospital.

Fuel Economy Essential this Winter

While it is at all times necessary to exercise constant supervision of the boiler room in order to secure proper economies, it would appear as if such supervision would be particularly necessary the coming winter, not only because of the dollars and cents involved, but because of the probable necessity of fuel conservation on the part of all.

From present indications it may be difficult to secure ample fuel supplies. Under such conditions it is natural that unsatisfactory fuel will frequently have to be used. With these conditions confronting him, every hospital superintendent should take immediate steps to see that his boiler room and heating equipment are in such condition as to operate most efficiently, and to improve the operation of the boiler plant so as to secure the greatest possible economy and the necessary even temperature for the institution.

Many things can be done in every boiler room which will increase the efficiency of the installation. The majority of institutions now employ steam heat. Boilers for the generation of steam, as a rule, are divided into two classes: the water tube (in which the water is contained inside the tube and the gases from the furnace pass over the outside), and the horizontal return tubular boiler (in which the water surrounds the tube and the hot furnace gases are exposed to the shell of the boiler and also pass through these flues). Various methods must be employed with either type of boiler to secure proper economy.

In many institutions the boiler room and power plant have not received the proper attention in planning and the result is that they are not particularly desirable places in which to work. At the same time many hospital executives have been prone to consider any kind of labor good enough for the boiler room. As a result the ability to shovel coal is regarded as the main qualification of a fireman.

Ventilation, light, fresh air, lockers, and washing facilities for the men cost but little and go a long way toward raising the morale of the boiler room force. A clean, light, airy boiler room will attract good men, whereas a dirty, dark hole will attract no one who can get another job, so if a superintendent wants to build up the efficiency of the boiler plant, let him first provide decent working conditions for the men and an attractive wage. A fireman can waste in one day in a power plant his entire month's wage.

Physical Equipment of Boiler Room

This article, however, is planned to deal with the physical equipment rather than the personal element in the boiler room. The many sources of loss in the boiler plant may be enumerated in brief as follows:

Dirt.—Both inside and out on boiler tubes. An accumulation of scale on boiler shells and drums. These are indicated by a high flue gas temperature and also can be observed by the slightest inspection.

Air leaks in boiler settings.—Too much attention cannot be paid to cracks in boiler settings. As soon as one is noted, it should immediately be plastered up. There are many good makes of plastic compound carried on the market for sealing up boiler settings and maintaining them permanently tight.

Ash pits.—On stoker-fired boilers, the ash pits and doors must be as tight as the setting for, if not, air will leak in and cause a loss in efficiency. On hand-fired boilers, the ash pit doors should be removed as there is a tendency for the firemen to attempt to regulate the amount of steam by opening and closing these doors instead of using the damper provided in the up-take from the boiler. There is no quicker way of wasting a large amount of fuel.

Baffle walls.—In the water tube type of boiler, the flow of gases from the furnace to the breeching is directed by a series of baffles constructed of fireproof material. In removing tubes and in the normal use of the boiler, these baffles often become broken and leaky. Hence the gases "short circuit" and give a high temperature at the up-take of the boiler with a consequent loss in boiler efficiency.

Bridge walls.—On water tube boilers, the bridge wall should be carefully maintained, especially at the point where it comes in contact with the first directing baffle or pass. On hand-fired return tubular boilers it was formerly the practice to build the bridge wall up very close to the shell of the boiler on the theory that the flames would impinge on the boiler surface and give a much better evaporation. This theory has been completely discarded. It has been found that the relatively cold surface of the boiler so chills the gases that they will not re-ignite.

Careless firing.—This divides itself up into many different phases. With stoker-fired boilers the usual tendency of the firemen is to run several short fires on a three-boiler plant rather than two long full fires and to use the third boiler merely for regulating purposes. Owing to the nature of the chain grate stoker, a large amount of air enters the furnace from the uncovered portion of the grate causing a serious loss in efficiency. On hand-fired boilers, the one-shovel method of firing is the best, but the most difficult to really put into effect. The tendency of a fireman is to fill up a furnace and then sit down. This means the introduction of a large quantity of green fuel into the fire; heavy black smoke indicating that a large amount of unconsumed gases is passing into the stack as the result. The banking of boilers also comes under the head of careless firing. It is difficult to lay down any rule for banking. It is simply a case of getting the men interested in seeing just what is the minimum amount of coal with which they can bank a boiler. It is clearly a case of individual effort.

Feed water temperatures.—One of the most common losses in the boiler plant is the failure to maintain proper feed water temperatures. These temperatures can be kept up by keeping sufficient steam supplied to the feed water heater. At the same time the heater must be kept clean. For example, if feed water has been heated to 200 degrees F. each pound of water delivered to the boilers as received represents 200 B.T.U. more heat than if pumped into the boiler at the average temperature of 60 degrees F., assuming that the boiler pressure is 125 lbs. per sq. inch. The heat required to make a pound of steam from the original temperature of 60 degrees is 1164 B.T.U.; this represents a saving of 200 B.T.U. plus 1164, or 17 per cent. Thus the saving is directly reflected in a corresponding reduction in the coal consumed. An approximate rule is that 1 per cent of coal is saved for each 11 degree rise in the feed water temperature, provided this is accomplished by heat that otherwise would have been wasted.

Common Causes of Fuel Loss

The following paragraphs outline various conditions that result in constant loss. In addition there are certain methods that can be applied to build up the efficiency of a heating and power system.

Water tube boilers should be provided with an accepted type of tube cleaner of a diameter that will just allow it to pass into the tube. If tube cleaners are employed that are too small, a large amount of scale is apt to remain in the tube.

In cleaning return tubular boilers, one of the many hammer cleaners should be provided; also some form of a steam jet soot blower. There are a number of efficient soot blowers on the market and these work out particularly well for water tube boilers. It is quite necessary, however, to see that employes use these blowers regularly (at least once a day), and that they are kept in proper repair.

A regular and careful inspection should be made of the ash pit and ash pit doors, and whenever a boiler is taken out of service, these pits should be thoroughly inspected.

Dampers.—For regulating the boiler, a damper in the uptake flue should be provided. Under no circumstances should firemen be permitted to regulate the steam by means of the ash pit doors.

Baffle walls.—These should be regularly inspected, using a strong high power electric light in the combustion chamber so that any leaks or cracks can be readily detected by the light shining through. High temperature cement should be applied for stopping these cracks and leaks.

Feed water temperatures.—In almost every hospital a large amount of steam is used for cooking, sterilizing and heating purposes. The steam in the engines of the electric plant, when such installations are used, is generally a small proportion of the total amount of steam generated by the boiler plant. It is of great importance, therefore, that these drips be so piped that all of this water is returned to a hotwell or surge tank at the boiler plant where it can be pumped into the feed water. This water contains a large amount of heat and is condensed steam, free from scale; raw water from wells or rivers is not.

The Boiler Room Appliances

There are many devices on the market for producing economies in boiler room operation. The following named instruments, accepted commercially, are reliable and thoroughly practicable. They are named in the order of their importance:

Recording pressure gauge.
Recording thermometers for feed water temperatures.
Draft gauges.

The value of these appliances will be self evident to the farsighted executive, and he will appreciate the results obtained from their installation.

Flow meters.—For metering the amount of water going into the boilers. If further refinement is desired, the boiler flow meter can also be used. This gives an indication of horse power.

Scales for weighing coal.—With a water meter and with means for determining the weight of coal, the evaporation, which is the measure of efficiency of the boiler plant, can be readily determined from day to day.

Automatic feed water regulators.—Two devices are involved in feed water regulation: first, the automatic regulator for feeding water into the boiler as it is needed. To make this device operate satisfactorily, it is necessary to employ on the boiler feed pump, a device known as an excess pressure boiler feed line regulator. The function of this valve is to maintain a constant differential pressure between the steam pressure in the boiler and the water pressure in the feed lines, thereby maintaining a constant hydraulic head across the valve of the automatic regulator. Unless this is done, results with the automatic feed water regulator can be poorer than hand regulation.

Damper regulators.—The damper regulator is a successful operating device operated by steam pressure from the boiler, which opens and closes the damper in the uptake as the steam pressure in the boiler varies. This in turn is a measure of the demand upon boiler plants. There are many satisfactory forms of damper regulators.

In general it may be stated that stoker firing is applicable to plants of 200-horse power boilers and above. Below this the size of the stoker becomes so small that it is not economical and a good hand fireman can give better results than the stoker. Above 200-horse power, however, it is difficult to get men to handle boilers satisfactorily. Furthermore the automatic stoker is a means of reducing labor. Another fruitful source of labor waste around power plants is improperly designed coal and ash handling systems. Too much attention and consideration cannot be given to this problem.

INFANT MORTALITY RATE FOR 1921 IS LOWEST ON RECORD

A record low infant death rate of 76 per 1,000 population is shown in the birth registration area of the United States for the year 1921.

The Department of Commerce will soon issue a bulletin, based on 1921 figures compiled by the Bureau of Census, showing for each state and each city in the birth registration area the number of births and the infant mortality rate, together with figures for 1920 for comparison.

These 1921 figures for a population of 70,425,705 show 1,714,261 births, 825,511 deaths at all ages, and 129,598 deaths under one year of age, which give a birth rate of 24.3 per 1,000 population, a record low death rate of 11.7 per 1,000 population, and a record low infant mortality rate of 76. In 1920 the rates for the birth registration area were: birth rate 23.7 per 1,000 population; death rate 13.1 per 1,000 population; and infant mortality rate 86.

For the state the lowest infant mortality rate (51) appears for Oregon, and the highest (98) for Delaware; for cities of 100,000 population or more the lowest infant mortality rate (50) appears for Portland, Oregon, and the highest (114) for Fall River, Mass.

THE CARE OF PATIENTS' CLOTHES*

By HAZEL A. GOFF, Superintendent of Nurses, Blodgett Memorial Hospital, Grand Rapids, Mich.

EVERY nurse has experienced misgivings in regard to the proper care of patients' clothes. Doubtless every executive in the administrative or nursing department of a hospital has spent some hours searching for mislaid patients' clothing or belongings.

Two main factors must always be considered regarding this subject:

1. The carelessness of individuals about their personal belongings, and; 2. The thoughtlessness of the average human being for the property of others.

We can never overcome the first consideration to any appreciable extent, but in the training of student nurses the second is a very vital problem. Its only solution is to establish a definite system of caring for patients' belongings and then adhere to that system. If the students have some part in working out the system they will slowly but surely learn to appreciate the value of other's property; it soon gets to be a habit and one of the good habits which they should form early in their training.

Receiving Ward Makes Problem Simplest

As to the system to be adopted, it depends entirely upon the type of hospital and the facilities at hand. Large hospitals, where patients are admitted to a receiving ward, usually have the simplest arrangement. After preliminary observations have been made and the patient accepted, he is taken in charge by an attendant, male or female as the case may be. In the bathroom his clothes are removed, tied in a bundle, labelled and placed in a chute. After the bath the patient is equipped with hospital clothing and taken to the ward designated. The chute from the bathroom usually ends in a sterilizing room, where the clothing is disinfected, bundled, tagged and stored.

In other institutions, with similar admitting facilities, the nurse makes duplicate lists of clothing, valuables and all other articles. This list is signed by the patient and the nurse. One copy is retained with the clothes and the original given to the patient. Another arrangement is to retain the duplicate with the patient's chart and have the original filed in the office in case the duplicate is lost. This same procedure is commonly followed where there is no receiving ward and the clothes are kept in lockers near the ward. Again, it is varied in that the clothes are simply listed in a book kept for that purpose, signed by the patient and the nurse and then placed in locker or clothes room. This is a less sure and safe way, but even so, is more of a protection to the patient than when he is allowed to look after his own things, which is the procedure frequently followed on private floors.

The advantages of a central receiving ward are several. One nurse can care for the clothes of many admissions in less time and with less confusion, as there is usually more room in which to work and less danger of clothes being mixed, for here, listing the clothes will not be sandwiched in between numerous other duties.

Tagging Clothes for Identification

On wards where the nurses are required to spend considerable time tagging and listing clothes, the question arises as to the value of time during a nurse's training spent in this way. There is no question but that this work can be done by an attendant as efficiently and there is no question about it not being a nursing procedure. Nevertheless, does it not teach three of the vital principles we are making every possible effort to "put across" to our nurses today? These are: respect for the property of others, promotion of accuracy and development of system. Following the natural order of things, one should be opposed to this method. The writer lived through three years of the most elaborate tagging and listing which caused her to make many silent vows on the subject. According to the more modern idea of training possibly the students were exploited a little in getting the work done in that manner, but all have been repaid many times in the valuable lesson they learned—that is to "have a care."

Different methods of tagging the clothes are used. Some fold all the clothes, do them up in a half sheet or clothes square and fasten the name and ward on the outside of the bundle. The disadvantage of this plan is that the bundle must be tied very firmly or some articles may fall out; in that case the clothes become badly crushed unless most carefully folded.

Another plan is to tag with name and ward all the outer garments, place hats in paper bags, wrap shoes and rubbers together, put underclothing in a bundle, tag it and list contents on other side of the tag. The outer garments can then be hung up so as not to become wrinkled.

The types of clothes' lists used vary with the management of the hospital. Some use a card system (Presbyterian Hospital, New York), others have a more elaborate form where clothes received after admission or clothes given to the patient during convalescence are noted (University of Michigan Hospital). For general use the form suggested by the committee on forms and records of the American Hospital Association is good excepting that it might better contain a space for extra articles to be recorded. Listing patients' clothes in a book is neither business-like nor efficient. It takes more time to make the list; the ward, date, or locker number are often overlooked and the book may be mislaid at the time it is most needed. It is in these details that nurses are most apt to be lax or thoughtless.

Lockers Should Be Well Ventilated

After listing patients' clothes the next consideration is storing them. Some hospitals have a central clothes room equipped with lockers, others have a room near the ward for this purpose. The only disadvantage of a central clothes room is the time spent running to and from the locker room which is usually in the basement or some other remote part of the hospital. The disadvantage of having lockers near the wards is that it is almost impossible to keep patients away from them. Some articles are given to convalescent cases and then difficulties follow. Locker rooms are seldom properly ventilated and frequently lockers are only half large enough.

In "The Organization, Construction and Management of Hospitals" by Dr. A. J. Oschsner and M. L. Strum lockers are described as follows:

"The only locker worthy of consideration in any hospital, be it a fireproof or non-fireproof building, is an all metal one, whether this be of the open type—namely, the wire mesh type, or the closed type."

*Read before Institute of Michigan State League of Nursing Education, Ann Arbor, Mich., June, 1922.

All of these have their advantages, as they are built with a view of ventilation and sanitary conditions. The closed type form of metal locker, known as the "knock down" type is probably the best on the market today, inasmuch as it can be taken apart in a few moments, thoroughly cleaned and renovated, and put together in the same space of time. These lockers are made with the enamel burned on, which with ordinary care, should last for many years.

"Built in" lockers are particularly to be condemned, as there are few instances where they do not become unsanitary, even with the best of care. They cannot be constructed by the ordinary carpenter in such a manner as to be irremovable and sanitary at the same time.

It is wrong to suppose that a locker room is one that can be used for no other purpose because it is dark and out of the way. It is as necessary to have sunlight and ventilation in this as in any other room in the building; in fact, it cannot be too strongly advocated that this be the rule rather than the exception.

Opinions Differ as to Closets

Clothes closets have been discussed in THE MODERN HOSPITAL by J. A. Hornsby and R. E. Schmidt. They state in part, "The question of having a private clothes closet or not to have one has been much discussed. Some hospital boards believe closets sanitary and that no good private room should be without them. Again other hospital boards refuse to have closets and maintain that a patient should come to the hospital with only one change of clothing and that these should be kept in metal lockers in general locker room and returned to the patient when required.

The closet adds a number of additional corners and surfaces which increase the labor of cleaning but there should be no danger if it is maintained in a sanitary condition. Inasmuch as but little clothing need be stored in them it is best to build a false ceiling immediately above the door, cutting off a number of feet of useless space which is difficult to clean, an unnecessary first cost and an unnecessary cost of maintenance."

Another plan for a clothes room is to have compartments built in "box fashion" in which to place the bundles of clothes and keep the room locked. The disadvantages of this scheme are that the clothes are crushed and such a room is seldom properly ventilated. The top compartments have to be reached with a ladder so it is difficult to locate the proper set of clothes readily.

In private rooms there is a different problem. In the first place most all private rooms are equipped with a closet and a dresser where the patient may keep his belongings. With this type of patient you find friends and relatives are constantly bringing things to him and taking things home and they feel most indignant if it is suggested that the articles be listed. However the writer feels strongly that they should sign duplicate clothes slips, stating that they wish to retain these things at their own risk. Then when articles are mislaid they do not have the same critical manner toward the hospital.

Valuables Must Go to Safe

There is no question about money and valuables—they should always be put in the safe immediately upon entrance. We have made quite a point of this. A framed sign is on the admitting desk and beside each elevator stating a few of the essentials, one of them being as follows:

"The hospital maintains a depository for all valuables, and patients upon admission should turn over to the admitting officer all moneys and valuables for deposit. The hospital will not be responsible for any valuables unless they are sent to the office and a receipt obtained."

This same statement is made under "Information for Patients" on the admission card which is given the patient in the doctor's office. There cards are placed under the glass on every dresser in the private rooms and every bedside table in the wards, so patients may read them. An envelope giving name, ward, date, valuables, name of patient and nurse, such as the one suggested by the American Hospital Association, is the most satisfactory way of filing valuables in the safe. Every effort should be made by the admitting office to care for these before the patient is sent to his room.

At Blodgett Memorial Hospital we have been extremely fortunate in the matter of lost clothing. Most of our difficulty has been with patients leaving things when they go home and these are usually patients who have special nurses. This is another argument for having the student nurses do a certain amount of the so-called "drudgery." They then remember some of these details after they graduate, and are more acceptable for hospital cases, thereby.

We have all articles which have been left behind sent to the training school office, tagged with the patient's name and room number. It would seem almost desirable for hospitals to have signs on the doors as they have in many hotels—"Stop! Have you forgotten anything?" At regular intervals the unclaimed accumulation of worldly goods is sorted over, cards sent to those who have left anything of value, requesting that they call or send postage for same. Then if the articles still are unclaimed they are turned into the linen room to which we occasionally apply for odd garments for charity cases.

Sense of Humor Is Essential

This is one place where it is well to have a sense of humor. For example, it took several telephone conversations, a couple of letters and an interview with six nurses to convince the widow of a very wealthy man that we had not appropriated two cotton handkerchiefs which she claimed her husband had with him when he entered. Compare this with a winter coat having a fur collar which a maternity patient has still not claimed, a pair of silver backed military brushes, a hair switch and two sets of teeth with ten gold crowns that we have in the office at present. Then again, someone will make a great effort and come a long distance to claim a worn-out pair of bedroom slippers. From our viewpoint, however, articles which do not belong personally to us must be considered valuable.

Some conclusions to be drawn from this article are:

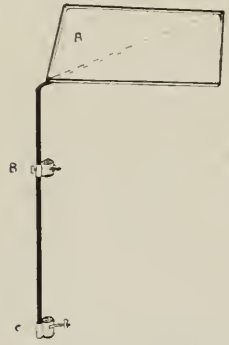
1. That definite system to protect the hospital is most essential in the care of patient's clothes.
2. That the system may be very simple but should meet with the demands of the particular institution.
3. That any system in a training school needs constant supervision to make it work. Automatic ones have not yet been invented.
4. That student nurses need a certain amount of this training to make them value the property of others, and to teach them accuracy, neatness and order.

In a drop of river water or a speck of road dust the microscope reveals to us life in myriad forms, each distinct, but sharing in the one great principle which animates all living things. Every one of these infinitesimal creatures fills a niche of its own in the universe.—Robert W. Mackenna.

A WARD DRESSING TABLE

By J. H. WOOLSEY, M.D., Instructor in Surgery, University of California Medical School, San Francisco.

An easily portable ward dressing table has proved to be indispensable in performing bedside dressings. The patient's bedside table is invariably overladen and it is poor technique to lay out a sterile field upon a patient's bed. Because of this I adapted a table, for our use at the University of California Hospital, from the "adjustable instrument table" employed in the operating room and sometimes known as the "Mayo table."



Ward dressing table adapted from so-called "adjustable instrument table" for use on ward surgical dressing-carriage.

This table consists of (A) a removable enameled tray seated in a horizontal frame to the corner of which an upright supporting rod is attached. The upright rod is in turn attached to the dressing carriage by two clamps, (B) and (C). Clamp (B) consists of a metal appliance lined with rubber to fit upon a corner post of the dressing carriage and a tunnel with a set screw through which

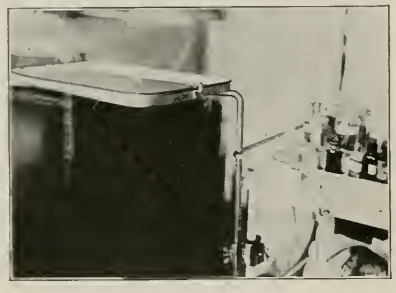


Table placed ready for use.

the upright of the dressing table may pass. Clamp (C) consists of a similar metal appliance to attach to the dressing carriage but with an opening only for one-half of its depth in which the dressing table upright may turn. Clamp (B) by the set screw holds the dressing table at any position desired, as when not in use, over the carriage. Clamp (C) regulates the height of the dressing table.

Such a table as this can be placed at the side of a bed, over a bed or at any point desired and yet when not in use may be placed over the carriage and so out of the way; it eliminates the delay of the nurse in finding a permanent level spot for the sterile field and leads to better technique in ward dressings.

Ward dressing table when not in use.

HOSPITALS NOTE DECREASE IN INDUSTRIAL ACCIDENT CASES

Industrial hospitals or institutions which receive injury and accident cases from milling centers must have noted the sharp decline in the number of such patients during the past year. A recent report of the U. S. Bureau of Mines shows that in 1921 there were only one-half as many accidents in mills and smelters, excluding iron blast furnaces, as in preceding year. Some figures on industrial accidents recently released by the U. S. Bureau of Mines follow:

Accidents at all mills and smelters, excluding iron blast furnaces, operated in the United States in 1921 resulted in the death of 27 employes and the injury of 4,494, according to reports received from operating companies by the federal Bureau of Mines. In the preceding year, 61 employes were killed and 8,863 were injured.

At milling plants, 10,047 men were employed, of whom four were killed and 1,214 were injured, as compared with 21 killed and 2,624 injured during 1920. The fatality rate in 1921 was 0.50 and the injury rate was 151.05 per thousand employes, based upon a standard of 300 work days per year, as against rates of 1.31 killed and 164.24 injured the year before. The total working time was 2,411,148 shifts, and represents an average of 240 days per man. The number of men employed represents a reduction of 37 per cent.

At the smelters 18,656 men worked 5,733,969 shifts, an average of 307 days per man, as compared with 24,944 men, 8,741,116 shifts, and 350 days per man in 1920. Fourteen men were killed by accidents and 2,129 were injured, or 0.73 killed and 111.39 injured per thousand 300-day workers. The corresponding rates in 1920 were 0.69 killed and 142.33 injured.

At the outside or auxiliary plants operated in connection with the mills and smelters, nine fatalities and 1,151 injuries occurred among 8,762 employes. The fatality rate per thousand 300-day workers was 1.08 and the injury rate was 138.54, as compared with rates of 1.11 killed and 116.19 injured in 1920.

Of the 1,214 persons injured at mills, 132 were hurt by falling, 130 by machinery, 108 by hand tools, 99 by falling objects, 73 by falling pieces of rock from sledging or crushing, 70 by crushers, rolls, or stamps, 70 by haulage equipment, and 64 by nails and splinters.

Of the 2,129 injuries at smelters, 401 were caused by burns from matte or molten metal, 287 by flying or falling objects, 179 by hand tools, 149 by haulage equipment, 146 by falls of persons, and 96 by machinery.

Of the 1,151 injuries to employes at auxiliary plants, 174 were caused by falling objects, 140 by hand tools, 125 by falls of persons, 90 by machinery, 78 by haulage equipment, and 70 by nails and splinters.

Answer a fool according to his folly.—Proverbs.

Occupational Therapy and Rehabilitation

Conducted by Herbert J. Hall, M.D., President, American Occupational Therapy Association, Devereux Mansion, Marblehead, Mass., and Mrs. Carl Henry Davis, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: Loring T. Swaim, M.D., 372 Marlboro St., Boston Mass., and Miss Mary E. P. Lowney, Room 272, State House, Boston, Mass.

OCCUPATIONAL THERAPY AT SOUTHEASTERN INDIANA HOSPITAL FOR THE INSANE

By Hazel Irene Hansford, Ph.D., Southeastern Indiana Hospital, Madison, Ind.

In January, 1922 an occupational therapy department was established at the Southeastern Indiana Hospital for the Insane at Madison, Indiana. The work was placed in charge of Mrs. Russel Doyne and she was given two girls, one of whom was to direct the work in the industrial room and the other one to help with the ward classes. Later another girl was added to the force.

Habit formation classes were held twice and three times each week in three wards on the female side. As yet no work has been done for the men. Later when the work became better established classes were organized on four other wards. Gymnasium classes were met weekly for four different groups of patients in the chapel or on the lawns.

In the four classes formed on the wards, arrangements were made to combine two wards for each class. There work of varying complexity was taught. Carpet rags, burlap and raffia were used as a medium for training. The most deteriorated cases often could do no more than ravel burlap. Some of these became quite proficient in this simple task and later were given more complicated tasks such as tying the burlap strings end to end, winding, coloring, weaving, braiding and sorting colors. Practically the same problems can be worked out with the use of rags. Two patients who in the past have been destructive are now kept busy cutting and tearing rags instead of their clothes. One of them tears the cloth into tiny bits with her fingers and another uses scissors to snip it into fine scraps. Spool knitting, various kinds of weaving and basketry are all used. The plan in all this work is to establish better habits of thought and action and as soon as one is firmly fixed to go on to something more complicated.

In addition to this work, the patients once or twice

A view of the occupational therapy work of the Southeastern Indiana Hospital for the Insane on exhibit at the Indiana Health Exposition last spring.

Calisthenics on the lawn is being employed in the treatment of these backward patients.

each week are taken to the chapel where they are given physical exercises and games varying in complexity according to their mental level. For some groups this work consists wholly of marching, hand ball, drop the handkerchief and other games. As soon as they master these simple exercises they are given something more difficult to do, such as calisthenics or folk dancing. Most of the patients look forward to these exercises and the effect has been to raise the morale of the wards, for they know that if their conduct is violent it will not be possible to take them from the wards. Thus all of those excepting the ones who are really confused and disturbed are encouraged to control their emotional reactions and to keep neat and clean in person.

Where formerly they tore their clothing, these two destructive cases of dementia praecox are now tearing and cutting rags into tiny bits.

Work outside the classes and the women's industrial room is often prescribed for certain patients by the medical staff. They are provided with work of use to the hospital and then shifted as their mental condition changes. For example a girl may be given work in the diet kitchen and as she improves or proves capable be transferred to the officers' kitchen or dining room. Often girls are given the advantage of thorough domestic training in the household of the superintendent of the institution before being sent home. Another part of the work which might be mentioned in the gardening class of ten patients taken in hand by Dr. Carrie Davis. The garden did not make much of a showing but the class itself is a great success.

From January 1 until the first of June, 147 patients out of a total of 588 or twenty-five per cent were reached by the classes in gymnasium and habit-formation. Thirty-two others were working steadily in the industrial room. Considering the fact that the greater part of the hospital work is done by patients and that these workers are not often included in the class work, the department has done well to reach this large percentage of the patients.

It is not only in finished undertakings that we ought to honour useful labour. A spirit goes out of the man who means execution, which outlives the most untimely ending. All who have meant good work with their whole hearts, have done good work, although they may die before they have the time to sign it. Every heart that has beat strong and cheerfully has left a hopeful impulse behind it in the world, and bettered the tradition of mankind.—R. L. Stevenson.

A class of deteriorated patients on one of the ward porches doing work varying in complexity from raveling burlap to knitting, crocheting and hand sewing.

A group of deteriorated patients learning to play "drop the handkerchief." If left alone they would be sitting on the wards indifferent to all surroundings.

COMPLETE oral hygiene as practised by nurses and other attendants is not only recognized as good administration, but is a necessary precautionary measure adopted by medical directors, superintendents and superintendents of nurses in the safeguarding of patients.

Interest in sanitary, healthy mouths of hospital personnel grows steadily. The subject will receive even more attention in the future.

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OCCUPATIONS OF THE INSANE*

By J. C. SPURZHEIM, M.D., Licentiate of the College of Physicians of London, and of the Universities of Vienna and Paris.

ALL practitioners who have taken care of insane people agree with respect to the usefulness of employment. It is, indeed, a fact that in those asylums for the insane, where labor makes a part of the regimen, a greater number of patients recover. Is it then not surprising that this important point is so little attended to in the erection and management of mad-houses?

Sufficient occupation of the mind is beneficial in two respects, in point of cure, and economical advantage. In the healthy state of the mind, idleness is the mother of many disorders, and in many insane, from want of suitable occupation, the disease is nourished; the patients indulge in their fancies, and injure their health by want of bodily exercise. In the asylums for the insane, however, we meet many persons of both sexes, vigorous, strong, and in many instances fully capable for manual labor. They loiter away their time in apathy and live often at the expense of the institution, while many economical concerns and the necessary affairs of the house might be done by such patients. Many, from previous habits, could be employed in the handicraft line, as whitewashers, carpenters, and tillers; others ought to be employed in the ordinary concerns of horticulture and husbandry, in digging, planting, weeding, wheeling; some might be employed in sowing, stone-cutting, twining ropes; female patients in washing, mending, getting up the linen, etc. It has been observed that, in all institutions for insane, the male patients who assist in cutting wood, making fire, and digging in the garden, and the females who are employed in washing, ironing, and scrubbing floors, often recover; while persons, whose rank exempts them from performing such services, languish away their life within the walls.

Occupation Necessary for Convalescents

It is understood that the labor ought to be relieved by sufficient rest, by recreation and amusement. The fatigue of the day would prepare the laborers for sleep and repose during night. Many individuals are very solicitous for some kind of occupation, and during their employment in moderate labor they never fail to enjoy a more happy state. It is evident that the temperature of the atmosphere is attended to at the same time. The rich ought to exercise the fine arts, ought to be amused with various games, such as bowling, cricket, billiards, and in general with such occupations as keep body and mind in activity. We meet, in many institutions, drawings of various kinds made by patients. Dr. Hallaran, therefore, wishes "to pay the earliest attention to the capacity of every individual, in order to ascertain, at the period of convalescence, the practicability of employing the mind by any species of bodily exertion."

Occupation is particularly necessary for convalescents. To that end, I propose for them a separate building, with workships for handicraftsmen, with grounds for tilling, and every other sort of occupation and amusement. The rich may cultivate music and painting, may read aloud entertaining books of history and travels, may walk and play. In what a dreadful situation must a man find himself, when, returning to reason, he sees himself surrounded by persons under all the different gradations of mental misery.

I could quote many facts in support of the truth that the insane more easily recover if body and mind are occupied. I shall copy only one fact from the work of Dr. Hallaran. "A young man, who had been an entire stranger at Cork, and who was remitted from a distant part of the country to the asylum in the usual form, came under my care in the state of acute mania, and continued so full three months without any intermission. The symptoms having at length given way, he was treated as a convalescent patient, and every means tried to encourage him to some light work, merely as a pastime, but all to no purpose. Though the maniacal appearance had totally subsided, he still betrayed an imbecility of mind that bordered closely on dementia, and it was found impossible to excite in him the smallest interest either for himself, or, in any measure, for that which had been proposed for his amendment. This man had nearly been ranked amongst the incurable idiots of the house, when by accident he was discovered in the act of amusing himself with some rude coloring on the walls of his apartment. From the specimen he had then given, he was questioned as to his knowledge of drawing; and he, having signified some acquaintance with that art, was immediately promised colors of a better description if he would undertake to use them. This evidently gave immediate cheerfulness to his countenance, and he shortly evinced an impatience for the indulgence offered to him. On his being furnished with the necessary apparatus for painting, he immediately commenced a systematic combination of colors, and having completed his arrangement, he requested one of the attendants to sit for him. This essay was sufficient to satisfy me that his recovery was not so remote as I had reason to suppose. The portrait was an exact representation of the person who sat before him; and in a few days there were several other proofs of his skill in this line, which bore ample testimony of his ability. He soon became elated with the approbation he had met with, and continued to employ himself in this manner for nearly two months; after which progressive improvement as to his mental faculties took place; when he was dismissed, cured, under the protection of some gentlemen amateurs, who took a kind interest in his preferment. He pursued his profession of miniature painting in this city for some time after, and has since, as I understand, removed to London where he practises it with singular success."

As the public establishments are not properly adapted to occupy the insane, it confers the more honor on the superintendents and managers who pay particular attention to this point and make the best use of the situation to which they are reduced by the plan of the architect.

What I must do is all that concerns me; not what the people think. This rule, equally arduous in actual and in intellectual life, may serve for the whole distinction between greatness and meanness. It is the harder, because you will always find those who think they know what is your duty better than you know it. It is easy in the world to live after the world's opinion; it is easy in solitude to live after our own; but the great man is he who in the midst of the crowd keeps with perfect sweetness the independence of solitude.—Emerson.

*The writer died in the year 1834, but his suggestions are still timely and show what advanced ideas he held.

Adv. page 46

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A POST-HOSPITAL COMMUNITY FOR THE HANDICAPPED

[A New Jersey plan that will be watched with interest is described in the following article. This or some similar organization will succeed some day in combining care and treatment of the handicapped with an opportunity to earn at least a partial self-support. Sound business management will be necessary for even a moderate return on money invested. The editors would like to see a small factory turning out a staple product established in association with a sanitarium for chronic invalids or convalescents. Certainly the out-of-door work of a farm would be valuable as affording healthful exercise for those who could bear the hard work. We would like to suggest green house work as suitable for all the year employment for certain classes of the handicapped.]—EDITORS' NOTE.

THE post-hospital community for the handicapped opened in June is located in the Somerset Hills, thirty-five miles from the city of New York, eight miles from Morristown, N. J. (13,000 pop.), and two miles from Bernardsville, N. J. Both the latter towns are reached by the excellent service of the Lackawanna railroad.

It centers around an industrial plant incorporated under the laws of the state of New Jersey, with a capital stock of $75,000, for the purpose of "providing post-hospital labor in handcrafts, and other handlabor for handicapped men and women." It does not include the tuberculous or the blind, but those physically crippled or disabled in other ways, chiefly the civilian handicapped who have been disabled through disease, injury or industrial accident.

Between the time of discharge from the hospital and a later return to normal industrial life lies a disastrous period for many people who have no home to go to and no money for maintenance, who are still unable to get back and forth to a job could one be procured, and who need physical upbuilding and renewed courage to meet a cripple's difficulties in earning a living. It is during this time that many become hopelessly pauperized and burdens upon city and state. The benefit gained by hospital care is frequently lost altogether, and the man or woman goes to the industrial scrap heap for lack of intelligent help at the right moment. The problem of this mental, moral and physical waste is increasingly important and especially acute just now.

Organized on Basis of Self-Help

That this need exists and is not covered by any existing organization is attested by letters from hospitals and social service organizations of all kinds. Excerpts from one or two of these are appended. The instant and widespread approval from those who know conditions also attests the practicality of the work. The corporation seeks to avoid duplication of effort, and to cooperate with any individual, institution, business or social agency which is interested in someone it may help.

It is organized on the basis of immediate self-help, taking the man and woman directly upon discharge from the hospital and offering, not charity, but a chance to earn at least maintenance until such time as they are able to return to normal industrial life. We do not take medical or surgical cases, and it is necessary that all workers be able to do a minimum of four hours' work a day, which will cover actual maintenance.

The handicapped are offered a market for such abilities as remain to them and instruction along practical lines. The aim is to restore them, as early as possible, to economic independence, and for this purpose we cooperate with such organizations as the Institute for Crippled and Disabled Men for further vocational education if needed and for placement in industrial positions. In the event of their being too heavily handicapped ever to cope with industrial conditions outside, they can frequently be taught to do certain sorts of work with us which will cover their living and enable them to remain on a self-supporting and self-respecting basis, without having to face the future as burdens on their families or society.

There is no discrimination as to color, creed or nationality.

Workers Govern Themselves

The workers are self-governed, establishing and enforcing their own discipline. As the ultimate success of the enterprise has a vital bearing on their own welfare and future, they are alert to protect themselves from the unworthy applicant.

The board of directors is made up of business men and executives. The work is planned around the central factors of success, excellence of product and adequate market. At present the industrial products is confined to certain kinds of wood-working, textiles, and wrought metal, which are fitted to the capacities and limitations of the handicapped worker. For these a market is already secured. Other work afforded consists of truck and poultry raising for our own use, clerical work, and the various duties connected with running the place. The group of workers forming the nucleus were all trained last winter to fit into their places.

An added source of revenue comes from a group of private patients who will pay sanitarium prices and be luxuriously housed in the administration building, 300 yards from the workshops and dormitories where they can have all the advantages of a convalescent sanitarium without its disagreeable features. They are sent to us by the orthopedic surgeons who wish them to have the benefit of occupational therapy.

The buildings were erected in 1913 at a cost of $350,000 and are exceptional in their solidity, durability and suitability to the needs of the enterprise. They are well provided with heat, light, baths and telephones. The main house is used for administrative purposes. The exceptionally large building of two stories and basement, which was formerly the garage and stable, remodeled inside and provided with the special conveniences needed by the disabled, makes an ideal workshop and dormitory building. The twenty-five acres of land afford, in addition to the truck, poultry, etc., various earning facilities as yet undeveloped. The adjoining farm of ninety acres with farm buildings, stock and implements is being held at our option for a year at a very reasonable price.

Details of Organization

The stock is common, (no preferred stock or bonds); it is sold at $25 par. It is sold with the proviso that it may eventually be bought back by the corporation and the income used to further the work.

The corporation owns the realty free and clear and will have sufficient money in the bank for a year's budget. If, at the end of that time, it should be deemed best to discontinue the work, the realty is saleable enough and its value so far in excess of the amount of capital stock as to make it readily possible to return the stockholders their money. The stockholders are thus fully protected and are guaranteed one of three things:

Adv. page 48

"America's Most Famous Dessert"

JELL-O

GALLON SIZE

EVERYWHERE hospital buyers are insisting on Jell-O because they find our Institutional size Jell-O is not a mere bulk product but that it is of exactly the same quality that has distinguished our domestic size package for so many years.

Diabetic Jell-O

WE are now prepared to furnish direct to physicians a new product which is sugar free, and of low protein content. It is an appetizing addition to the dietary in diabetes, glycosuria and obesity. Correspondence is solicited. All letters should be addressed to the attention of our Chief Chemist.

THE GENESEE PURE FOOD COMPANY
Le Roy, New York

(1) Interest and dividends for a period of years.

(2) Re-purchase by the corporation at the end of the first year, or

(3) At the end of the first year, their money back with interest to date.

We feel that the investment offers no more risk than a large proportion of stock already on the market; in addition to that fact, every share sold helps some man or woman in a difficult struggle for a decent, useful life. Each one of the initial group has good brains, ambition and self-respect, but for every one this opportunity means salvation from Welfare Island or worse, while for several this prospect ahead turned the scales between life and death.

Stockholders and those standing back of the work include Miss Barger, sister of the treasurer of the New York Central Railroad; Mrs. Henry Villard, daughter of William Lloyd Garrison; Dr. Charles Jaeger, the well-known orthopedic surgeon; Rev. William Whiting Davis; R. Burton-Opitz, M.D., College of Phys. & Surg. and Columbia University; and Dr. Winford H. Smith, director of Johns Hopkins Hospital, Baltimore.

The Board includes the following: George F. Clover, executive head of St. Luke's Hospital, New York; James Morey of Lakewood and New York; Standish Chard, corporation lawyer; John Culbert Faries; Kenneth V. Carman and others equally in touch with business problems.

The following excerpts from letters indicate the need of such a community:

"That the plan is organized on a business, rather than a charitable basis, seems to me to commend it at once as valuable. The great need of some development of this sort is too obvious to need comment."—From Annie W. Goodrich, Department of Nursing and Health, Teacher's College, Columbia University, and Director of Nurses, Henry Street Settlement, New York.

"Your proposal occupies the safe middle ground between pauperizing charity and hard-hearted indifference.

"Even the best of us—the strongest I mean—sometimes wonder whether the struggle is worthwhile. How much more heavily must this doubt bear upon the worker who is struck down by illness or accident, whose moral and physical strength has been sapped by pain and whose connections with business and industry have been broken.

"It seems to me your plan will make men over. . . . . I wish you every possible success."—Edgar Dawson, M.D., Professor of History and Political Science, Hunter College of the City of New York.

"I am firmly convinced of the fact that there is great need for machinery for dealing with the physically handicapped. Your conception of the plan by which to meet this need is excellent. . . . . Furthermore, I believe that the establishment of such machinery is very necessary to supplement our hospital system, in order to make possible the carrying through of medical treatment to a conclusion, which restores the patient to full usefulness."—Winford H. Smith, M.D., Director, Johns Hopkins Hospital, Baltimore, Md.

The managing director, Miss Spencer, has devoted several years to special preparation for this work, in addition to long study of arts and crafts, here and abroad. She has lectured and written on the subject and has her diploma in occupational therapy from Teachers College, Columbia University. Recently she has made a practical first-hand study of the needs of handicapped workers, having taught for a year in a hospital for chronic diseases and done executive work in other institutions.

BYRDCLIFFE SCHOOL HAS SUCCESSFUL SUMMER COURSE

By KATHRYN ROOT, Medical Workshop, Stamford, Conn.

The Byrdcliffe School of Occupational Therapy concluded its 1922 session on August 31. The school was conducted this year by Miss Bertha Thompson, a resident of Woodstock, a master craftsman, and an experienced occupational therapist. She was assisted by Miss Zelma Steele and Mr. Edward Thatcher, also of Woodstock. Both of these latter are professional craftsmen of great skill and considerable reputation and were valued instructors in the school in 1921.

The courses given were in basketry, clay modeling and pottery, wood-carving, leather tooling, tin-can toys and copperwork, weaving and a group of minor crafts.

No pupil was permitted to carry more than three subjects, each of which had to be pursued for at least a month—two months, if desired—an arrangement which insured the acquirement of a reasonable degree of proficiency in the crafts chosen. The efficient organization of the school made it possible for each student to progress as rapidly as her capability and inclination determined, and allowed her to concentrate on the subject which she personally needed, a matter of great importance to an aide with limited time for post-graduate study.

With this freedom, Miss Thompson combined thoroughness, requiring that each process be clearly understood and carefully executed.

The class of 1922 has proved the summer work well worth while and advises any aides who need further training in the crafts to go to Woodstock next summer.

THE ROLL CALL

MEMBERS IN STATE SOCIETIES

ILLINOIS		NEW YORK	
Active	54	Active	160
Associate	2	Supporting	47
MANITOBA		ONTARIO	
Active	30	Active	95
Associate	12	PENNSYLVANIA	
Honorary	2	An association of occupational therapy is being organized. At the present 20 aides in active service have joined, and it is expected that the association will grow rapidly.	
MARYLAND			
Active	75		
MASSACHUSETTS		WASHINGTON, D. C.	
Active	149	Active	30
Sustaining	27	Associate	2
Life	12	WISCONSIN	
MICHIGAN		Active	50
Active	30	Associate	6
Associate	10	Sustaining	4
MISSOURI		Honorary	5
Active	28		
Board	11		
Sustaining	124		

A CALIFORNIA DESERT ROMANCE

Once upon a time a traveler went forth to assist some friends who had gone on before him and lost their way in the California desert. He provided himself with food, filled his canteen with water and started on his way armed with the hope that his steps would be guided in the right direction. But the days went by, he found no trace of his friends and he lost his way. Then his supplies gave out and no more water could be found. He stumbled about in his misery until all hope had gone when he lay down to take death as he thought it had come. But it did not come. Instead a kind stranger found him and took the dying man to his camp which after all was not very far away. There he was fed and refreshed and directed back to the home he had left, which he reached in safety, his heart troubled over the loss of the friends who never were found but filled with gratitude to the stranger who had befriended him. After many years time brought the traveler and the stranger together again, when they met at Olive View, a branch of Los Angeles County Hospital, and the traveler, Mr. James M. Lewis, steward's assistant, who has been at that institution since its opening day, recognized the good Samaritan, Mr. Lester J. Newberry, who has been just now appointed general maintenance man. This story has been enacted many times in Death Valley but never, we venture to say, with such a happy conclusion.—From the *News Bulletin* of the Department of Charities, Los Angeles County, Cal.

Adv. page 50

Kirsch "Fresh Air" *Swinging* Curtain Rod

The ideal rod for hospitals

Illustration shows Kirsch Swinging Curtain Rod pictured in use above. A slight pull on curtain and rod swings —more light on dark days, more air at night. Another slight pull and curtain closes.

Simplicity itself.

Kirsch "Fresh Air" Swinging Curtain Rods permit the curtains to be swung open, insuring perfect ventilation.

They give the same draping effects as the regular line of Kirsch Extension and Cut-to-fit Curtain Rods.

There's a Kirsch Rod to fit every window and to give any draping effect.

Kirsch Curtain Rods are the most popular window draping fixtures and in the greatest demand.

Their flat shape provides ideal support for curtains. The Velvetone Finish stays like new indefinitely.

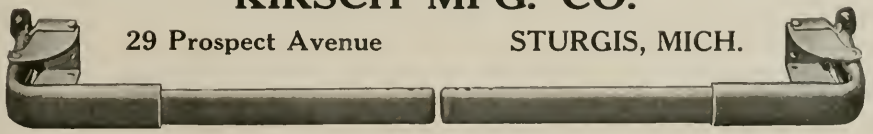
Write for catalog and full information

Our institutional department is maintained for the very purpose of giving desired information to hospitals and other institutions. Any questions gladly answered without obligation.

Catalog fully describes the Kirsch Swinging "Fresh Air" Curtain Rod, as well as our other rods. Gladly mailed on request.

KIRSCH MFG. CO.

29 Prospect Avenue **STURGIS, MICH.**



MEETINGS, CONVENTIONS AND CONFERENCES

DIETITIANS HAVE INTERESTING ANNUAL SESSION

AS REPORTED BY MISS MARION PETERSON, SUPERVISOR OF ADMINISTRATION, DEPARTMENT OF DIETETICS, LAKESIDE, HOSPITAL, CLEVELAND, OHIO.

THE fifth annual meeting of the American Dietetic Association was held in Washington, D. C., October 16-19, at the New Willard Hotel. Registration began at 9 a. m. Monday morning, and the opening session was called to order at 10 a. m. by the president, Mrs. Mary de Garmo Bryan. After a few words of welcome, Mrs. Bryan turned the meeting over to the chairman of the education section, Dr. Ruth Wheeler, professor of dietetics, University of Iowa Medical College, Iowa City.

Dr. Wheeler told briefly of the work of this section, and introduced Mrs. Agnes O'Dea, Johns Hopkins Hospital, Baltimore who gave an interesting history of the dietitian, showing the rapid development of her position from the early time when she was a wholly untrained and unspecialized individual to the present. Today we find the dietitian highly specialized and excellently trained, organizing and administering large departments of dietetics.

Miss Breta Luther, dietitian at Children's Hospital, Boston, Mass., presented a report of a survey which the committee made to determine the nature of courses offered to student dietitians and student nurses in hospitals. The courses for student nurses varied from a course of twenty hours to one of ninety which was being offered some hospitals. It was suggested that the course should be broad, with class periods not to exceed two hours. There should not be a large amount of outside reading, nor should the endurance be overtaxed by too frequent reviews. The work must be thorough and carefully planned, and presented in the most interesting manner. The committee outlined a course for student nurses, and copies of this were on sale at the information booth.

Recommends Nine-Month Course

Dr. Wheeler next spoke of the "Dietitian of the Future." From her grandmother, the dietitian gets her reserve, her good health, her poise, and her general good physical condition and to these inherent qualities she adds a degree from a recognized college or university with a major in home economics. She must have a broad scientific training with a thorough knowledge of metabolism. She must also be trained in organization, in practice and management, in care of food supplies and modifications of diet. The dietitian may be a technician, or a specialist in dietetics in a food clinic. She must take time to prepare for her administrative power. Institutional housekeeping and teaching nurses cannot be covered in a three months' course of training. Salary and rank are not important in the beginning.

Miss Emma Gunther, Teacher's College, Columbia University, told of conditions in China, in a most interesting way. She said, that the Chinese have an experimental and an open mind, and are eager to learn. Miss L. Ray Balderston, Teachers' College, Columbia University, discussed the housewife's problems in China.

The first speaker at the afternoon session was Dr. Elliot P. Joslin of Boston, who emphasized the relation between the dietitian and the diabetic. Overfeeding of the diabetic should be carefully avoided, since this condition only intensifies the symptoms. The function of the dietitian is to educate the patient, and see to it that his diet is very strictly adhered to. It is not necessary to teach him to figure the diet to the smallest fraction, but he can learn how to plan his diet in the easiest and most practical way.

Dr. P. L. Marsh of the University Hospital, Ann Arbor, Mich., discussed "The Construction of Diabetic Diets in Accordance with Metabolic Laws." His first principle is that the actual material metabolised is not identical with the food given, even though it be completely digested. Therefore fasting for desugarization is illogical, because you can't have an actual metabolic rest.

Dr. J. W. Hayes, Howell Publishing Co., New York, in his paper on "Psychological Aspects of Some Problems in Administration," spoke of the psychology of behavior, and said that there is a definite relation between people that work. Personnel management means a job well done by a satisfied worker. We must adjust the job to the man and the man to the job. The relation of a man to his job pertains to the psychology of adjustment. The health of the individual is largely dependent upon a correct adjustment.

Miss Laura Comstock of the Eastman Kodak Company, Rochester, N. Y., told of the "Nutrition Experiment in Industry" in their plant, where the underweight and undernourished office workers are all given a pint of milk a day furnished by the company. They have frequent conferences with the dietitian, tell her their trouble, are weighed and examined frequently, and the results are very satisfying. So far the work has been done with the office people only, but it is to be extended to the factory workers in a very short time.

Monday evening all delegates, members and friends gathered in the assembly room for dinner. The president, Mrs. Bryan, gave a history of the association from the time of its founding to the present, told of the many things it has accomplished, and the many plans its mem-

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CASTLE

"Any Sterilizer Troubles Today?"

(The Hospital Superintendent and the Surgical nurse were talking—Series V)

"Yes, Doctor, those sterilizers in the Maternity Department are all out of kilter again."

"*But we just overhauled them in the spring.*"

"I know, but they just don't stand up. The instrument sterilizer leaks again; it takes two girls to get the tray out of the utensil sterilizer, and we simply can't melt Diack Controls in the dressing sterilizer."

"*How long have you had those sterilizers, Miss Smith, and how much did they cost.*"

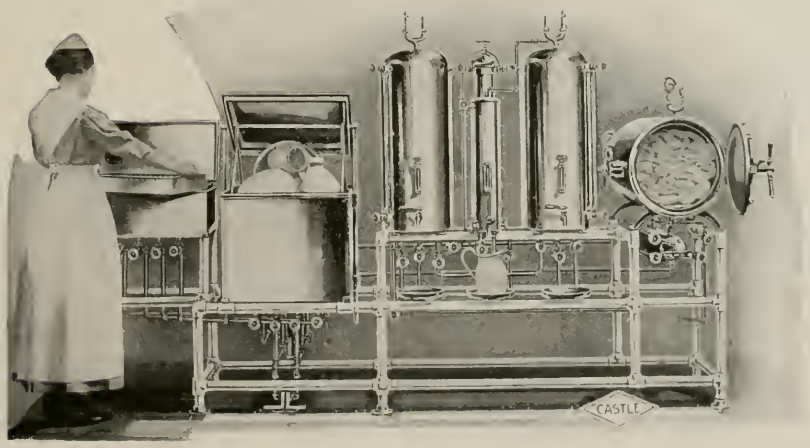
"Six years, and we paid $1100."

"*They were cheap, but how much for repairs?*"

"About $400.00."

"*Good Heavens! They're luxuries. We can't afford them. Those Castle Sterilizers, on the other hand, have been in almost as long, seen twice as much use and the total repair bill is $5.00 for a new thermometer. Get a price on what you need from the Castle people, Miss Smith, and if we have enough money left at the end of the month we will buy them.*"

"All right, and I'll send them a sketch of our room and let them suggest the right arrangement. There is no charge for that."



Send for Castle Sterilizer Specifications

WILMOT CASTLE COMPANY, 1151 University Ave., Rochester, N. Y

Makers of the largest line of Sterilizers for Hospitals, Laboratories, Physicians and Dentists

bers have for future development. Asst. Surgeon General F. C. Smith in a delightful talk traced the dietitian back to ancient countries and times and found her counterpart everywhere. He also spoke of the excellent work the dietitian did in the war.

Maj. Julia Stimson, chief of the U. S. Army Nursing Corps, suggested ways in which the American Dietetic Association can grow and thrive. She suggested a placement bureau, which the A. D. A. already has and also an executive office, with an executive secretary.

Miss Minnegerode of the U. S. Public Health Service told of the work of that organization, and spoke of the work of the dietitian in that group. Miss Clara D. Hayes of the American Red Cross told of the Red Cross dietitian service, of how it had been started under the nursing service, but had grown until at present it has offices of its own, and is a separate organization. Mrs. Hallie B. Corsette spoke of the work of the dietitians in the Public Health Service, of the spirit of service which is so evident, and the cooperation they are getting in this work. Col. Merritte W. Ireland thanked the dietitians for their work in the recent war, told of the importance of the dietitian and of what she means to the army hospital.

The meeting Tuesday morning was opened by Miss Rena S. Echman, director of housekeeping and dietetics, University of Michigan Hospital, Ann Arbor, Mich. The session was a joint meeting of the sections of dietotherapy and administration.

Dr. L. H. Newburgh of the University Hospital, Ann Arbor, read a most interesting paper on "The Role of High Protein in the Etiology of Nephritis." He said that in a search for the cause of nephritis, the theory of bacteria has been discarded except in some cases of the very young and acute cases where it could be absolutely traced. In 1916 the theory of wrong diet was carefully studied, and some rigid experiments were made with egg white casein and soy bean protein. Lesions occurred in six months, also albumen in the urine and the kidneys was increased. This was true of the soy bean meal as well as of the animal proteins, showing that an excess of vegetable protein is also detrimental.

Miss Dorothy Stewart of the University of Michigan Hospital, Ann Arbor, read a most interesting paper telling of the "Technical Preparation of Special Diets." They have just opened up a new metabolism ward made from an old ward diet kitchen. At present most of their diets are diabetic. The diets are all weighed, prepared and served directly to the patients from this metabolism kitchen. They have a graded system of diets.

Dr. LeRoy E. Parkins, assistant superintendent of Peter Bent Brigham Hospital, Boston, in an interesting paper, emphasized the fact that hospital food costs include cost in money, labor and thought.

The concluding paper of Tuesday morning's session was by Henry C. Wright of the Hospital and Institutional Bureau of Consultation, New York, on "Getting Food to the Patients." The first thing of importance in this connection, says Mr. Wright, is to safeguard the patients from the noise and odors of the serving room.

Delegates on Tuesday afternoon enjoyed inspection tours to the Walter Reed General Hospital and to the Agricultural Bureau, Office of Home Economics, and government hotels.

Miss Octavia Hall of Peter Bent Brigham Hospital, Boston, presided at the session on Tuesday evening. Mrs. Mary Schwartz Rose of Teachers' College, Columbia, presented a helpful paper on "Nutrition and Diet in Childhood" in which she enumerated several experiments with children. Her recommendation was that each child get a full quart of milk a day, in addition to other easily digested and nourishing foods.

Dr. Alfred Hess of New York talked on "The Relation of Hygiene to the Growing Child." His remarks were based for the most part on an exhaustive study of rickets, which shows that there is practically no rickets in summer, while there is a great deal in winter. This he attributed in some degree to lack of sunlight and urges that children not be wrapped up too tightly. Whenever possible their limbs should be exposed to the sunlight, he says. He further noted the use of tomatoes as a preventive measure for scurvy.

The report of Mrs. Gertrude S. Mudge's committee on the Italian Dietary Survey on Wednesday morning was well received. It is to be printed and widely distributed.

"The Interrelation of the Dietitian and the Social Worker" was the topic of a helpful paper by Miss Ida M. Cannon, director of social service at Massachusetts General Hospital, Boston. Good cooperation anl loyalty between these two departments whose work so frequently overlaps was the theme of her address.

Fatigue, fear, excess exercise, no sunlight, too little sleep and bad teeth are some factors other than food that influence nutrition, said Miss Lucy Gillett, director of nutrition of the A. I. C. P., New York, in her address.

Philadelphia's outstanding work in nutrition activities was reviewed by Miss Anna Louise DePlanter of the Child Federation of that city. There are thirty-two classes for undernourished children in schools, hospitals and settlements in Philadelphia.

The fundamental motives, hunger and thirst, were discussed by Dr. Walter Cannon, professor of physiology at Harvard Medical School, in an illuminating address on Wednesday evening. Hunger, he declared, is distinct from appetite which is an interest in a previous experience. Hunger may be lessened by smoking, by hard exercise and by tightening the belt, but it returns again. Among the causes of thirst, he enumerated too much air, fear, fever, diabetes and other general causes.

At the business session on Wednesday afternoon the following officers were named:

President, Octavia Hall, Peter Bent Brigham Hospital, Boston.

First vice president, Mrs. Hallie Corsette, U. S. Public Health Service, Washington, D. C.

Second vice president, Miss Effie Raitt, Washington University.

Secretary, Miss Breta Luther, Children's Hospital, Boston, Mass.

Treasurer, Miss Anna Boller, Chicago.

Miss Genevieve Field presided at the Wednesday evening session. Addresses were given by Dr. Orton of the Department of Agriculture on "Vegetables for Diabetics" in which he stressed the possibilities of the more uncommon vegetables; by Miss Marjory Hulsinger of Barnes Hospital, St. Louis, on "The Food Service for Ward Patients;" by Miss Daisy Treen on "Food Service for School Children;" and by Miss Mary Lindsley, manager of the government hotels at Washington on "Food Service for the Hotel."

On Thursday a number of the delegates went to Baltimore where they enjoyed a special program at Johns Hopkins Hospital, had luncheon at that institution and inspected it and its clinics.

Exhibits at the fifth annual session were most interesting and the entire meeting was declared a great success. There were 293 dietitians registered.

Adv. page 54

The Ariston Line

STANDARDIZATION OF FOOD SERVICE IN HOSPITALS

IS Always Fine

COCOA—*The Cold Weather Drink*

COCOA comes from the bean of the cacao tree, as does chocolate also. The fat in the bean is called cocoa butter.

The largest producers are the Gold Coast, West Africa; Bahia, Brazil; Guayaquil, Ecuador. The largest consumers are the United States and Germany.

Cacao trees are planted 15 to 30 feet apart, begin to bear in four years, and may bear for 100 years. The yield is from 2 to 6 pounds of cured beans per tree. Pods have been known to weigh 3½ pounds, with 40 to 50 beans per pod.

The trees grow best at about 1,000 feet above sea level, and they require much moisture. Young trees require shade.

After the beans are gathered they require a week or more to dry thoroughly. They are then roasted and their shells removed. The nibs or kernels are ground with steam heated rollers, and the cocoa mass runs out in semi-liquid form.

The value of cocoa mass is determined by the percentage of its cocoa butter content.

Bitter chocolate is the cocoa mass with the butter fat left in it. Addition of sugar and vanilla flavor makes sweet chocolate.

Cocoa is made by reducing the percentage of butter fat. In our Ariston Cocoa the percentage is upwards of 22 per cent, making an agreeably rich beverage, truly nutritious.

The Ariston Cocoa is put up in 5-lb. friction-top cans, as also in 50-lb. and 100-lb. drums. Large quantity sales enable us to make very attractive prices.

OUR GOODS and OUR SERVICE

We Import: Coffees and Teas. We Supply: Cocoas, Spices, Candies, Etc.
We Manufacture: Gelatine Desserts, Flavoring Extracts, Baking Powders
Brosia Meals (for Soups, Etc.) - - Pie and Pudding Powders
Magic Solvent—The Wonder Cleanser - - Other Ariston Goods

Coffees are roasted on orders as received
All goods sold are strictly guaranteed
All our goods are always pure and fresh
Prices are always reasonable and right
Packages of sizes convenient for institutions

Sales are made direct, to institutions only
We give personal service on every order
Orders received by noon shipped same day
Special attention is given to mail orders
Charges are prepaid on shipments by freight

1892 CALUMET TEA & COFFEE COMPANY 1922
GEORGE W. WALSH, PRESIDENT
409-411 WEST HURON ST., CHICAGO, ILL.

MEETING OF MISSISSIPPI VALLEY CONFERENCE ON TUBERCULOSIS IS FRUITFUL

A SHORTAGE of more than 10,000 beds for proper hospitalization of tuberculosis patients exists in the twelve states of the Mississippi Valley, according to Murray A. Auerbach, executive secretary of the Indiana Tuberculosis Association in his address before the Mississippi Valley Conference on Tuberculosis held in Milwaukee on Oct. 9-11.

"Using the Framingham demonstration figures," Mr. Auerbach said, "there should be approximately 20,000 beds for tuberculosis patients in the Mississippi Valley states. There are available, actually 9,830 beds, less than 50 per cent of the number needed.

"As far as sanatorium capacity goes, this may appear to be a fairly good record. It is well known, however, that some states have made very little provision for the housing of tuberculous patients. To the large cities really goes the credit of establishing a fairly adequate number of beds; in fact six cities have provided about one-half of the number of beds now available in the valley."

The Mississippi Valley Conference on Tuberculosis, comprising workers in all branches of the tuberculosis field in the states of Wisconsin, Minnesota, North Dakota, South Dakota, Nebraska, Iowa, Missouri, Illinois, Indiana, Michigan, Ohio, and the city of Chicago, attracted a registered attendance of 400 delegates and a total attendance of approximately 700 persons. The conference was held in the Hotel Pfister. The last day of the meeting was set aside to sectional meetings, at which time the Mississippi Valley Sanatorium Association held its sessions at Muirdale and Blue Mound sanatoriums. Approximately 200 delegates attended these sessions.

Men and women of national reputation in the tuberculosis field addressed the conference, including Dr. Lawrason Brown, president of the National Tuberculosis Association; Dr. Linsley Williams, managing director of the National Tuberculosis Association; Dr. David T. Stewart, superintendent of Ninette Sanatorium, Ninette, Canada; Dr. M. P. Ravanel, bacteriologist and former president of the national association; Miss Adda E. Eldridge, president of the American Nurse's Association; Owen R. Lovejoy, general secretary of the National Child Labor Committee; and Dr. David R. Lyman, superintendent of Gaylord Farm Sanatorium, Wallingford, Conn.

Dr. Patterson Heads Association

At the annual election of officers of the Mississippi Valley Conference, Dr. Robert G. Patterson, Columbus, Ohio was elected president; Mrs. Theodore Sachs, Chicago, vice president; James Minnick, Chicago, secretary and treasurer. Evansville, Ind. was chosen as the next convention city.

Dr. J. W. Coon, medical director, River Pines Sanatorium, Stevens Point, Wis. was elected president of the Mississippi Valley Sanatorium Association, and Dr. E. B. Pierce, superintendent, Michigan State Sanatorium, Howell, Mich., secretary-treasurer.

Two subjects of particular interest to institutional executives were that of care of the tuberculous criminal and the question of payment for sanatorium care on the part of the patient. Theodore J. Werle, Lansing, Mich. discussing "The Tuberculous Criminal and the Criminally Tuberculous" stated that many sanatoriums are having trouble with patients sent to them for treatment from penal institutions over whom no adequate control can be exercised. This class, together with the occasional incorrigible patient, constitute a group for which provision should be made for separate housing, according to Mr. Werle. He further advocated the parole of prisoners suffering from tuberculosis so that they could be given proper medical attention with a proviso that they be returned to prison to complete their terms when a cure had been perfected.

Dr. George T. Palmer, Springfield, Ill., president of the Illinois Tuberculosis Association and medical director of the Palmer Sanatoria, Springfield, urged the placing of all public sanatorium beds on an absolutely free basis. Dr. Palmer stated that in all public sanatoriums for the treatment of tuberculosis in Illinois, the patient is treated without charge, regardless of social position and that an effort is being made to educate the public to think of free sanatorium care on the same basis as they would think of free schooling, and to eliminate from the public mind the idea that free sanatorium treatment classes the patient as a pauper.

Says War Did Not Increase Tuberculosis

Dr. Palmer, who was one of five men in the United States selected by the government to standardize methods of diagnosis, examination and treatment in government sanatoriums, made the statement that "the war probably did not increase tuberculosis. The reason we have so much tuberculosis among soldiers, sailors, marines and nurses is because these groups have had so many physical examinations as compared to the civil population. Take a similar number of young girls and give them the same number of examinations given the soldiers and you will find just as much tuberculosis among them."

Dr. W. H. Watterson of the staff of the U. S. Veteran's Bureau Hospital No. 76, Maywood, Ill. presented the report of the committee on the problem of the tuberculous ex-soldier.

Miss Adda E. Eldredge, president of the American Nurse's Association, stressed the necessity of proper instruction of undergraduate nurses in tuberculosis work, recommending a closer affiliation between hospital training schools and tuberculosis sanatoriums, and demanding that a proper course of instruction be provided in the sanatorium after the affiliation had been completed.

A note of optimism carried through the entire conference. In the face of a steadily falling death rate, with the facilities for carrying on the fight broadening and constantly intensifying, it was natural that the delegates view the existing situation with satisfaction and optimism. Dr. David R. Lyman, superintendent of Gaylord Farm Sanatorium, Wallingford, Conn. in speaking before the annual dinner expressed the opinion that the fight against tuberculosis had reached the third stage. That the first or formative stage had been followed by the era of organization and with this foundation laid, the work was now launching into the third stage, that of accomplishment.

Dr. M. P. Ravenel, University of Missouri and a former president of the National Tuberculosis Association, recognizing the great accomplishments of the past and the reason for an optimistic view of the situation, added a needed note of caution.

Adv. page 56

Look at the trays—they tell the story

There is no better evidence of what patients like to eat than that of the trays, after service.

Serve any one of the score of puddings made with Minute Tapioca. Then look at the trays when they come back to the kitchen. The empty dessert dishes show how well patients like Minute Tapioca. It is the kind of food they have at home, and they want it served often.

As an energy-producing food and one easy to assimilate, Minute Tapioca stands very high. Many leading hospitals list it as a staple item and are never without it.

Minute Tapioca

It requires no soaking

Student nurses and anyone who has anything to do with the preparation of food also approve of Minute Tapioca. It is always ready for use. It requires no soaking and can be cooked thoroughly in fifteen minutes.

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MINUTE TAPIOCA COMPANY, 1311 Jefferson St., Orange, Mass.

Makers of Minute Tapioca, Minute Gelatine, and Star Brand Pearl Tapioca

LIST OF APPROVED HOSPITALS

Continued from page 429

St. Luke's Hospital, Cleveland
St. Mary's Hospital, Cincinnati
St. Rita's Hospital, Lima
St. Vincent's Hospital, Cleveland
St. Vincent's Hospital, Toledo
Springfield City Hospital, Springfield
Toledo Hospital, Toledo
University Homeopathic Hospital, Columbus
Youngstown Hospital, Youngstown

50 to 100 beds

*Alliance City Hospital, Alliance
Bellaire City Hospital, Bellaire
Bethesda City Hospital Zanesville
Children's Hospital, Columbus
Children's Hospital and Mary Day Nursery, Akron
Deaconess Hospital, Cincinnati
*Fairview Park Hospital, Cleveland
Flower Hospital, Toledo
Glenville Hospital, Cleveland
*Good Samaritan Hospital, Sandusky
Lakewood Hospital, Cleveland
*Lima Hospital, Lima
Mansfield General Hospital, Mansfield
*Massillon City Hospital, Massillon
Maternity and Children's Hospital, Toledo
*Memorial Hospital, Fremont
Mercy Hospital, Canton
Mercy Hospital, Columbus
*Newark City Hospital, Newark
Robinwood Hospital, Toledo
St. Ann's Infant Asylum and Maternity Hospital, Cleveland
Salem Hospital, Salem
Scarlet Oaks Sanitarium, Cincinnati
Schirrman Hospital, Portsmouth
*Warren City Hospital, Warren

OKLAHOMA

100 or more beds

St. Anthony's Hospital, Oklahoma City
State University Hospital, Oklahoma City

50 to 100 beds

*Wesley Hospital, Oklahoma City

OREGON

100 or more beds

Emmanuel Hospital, Portland
Good Samaritan Hospital, Portland
*Hot Lake Sanatorium, Hot Lake
St. Vincent's Hospital, Portland

50 to 100 beds

*Portland Sanitarium, Portland
Portland Surgical Hospital, Portland
*Sacred Heart Hospital, Medford

PENNSYLVANIA

100 or more beds

Allegheny General Hospital, Pittsburgh
Allentown Hospital, Allentown
Altoona Hospital, Altoona
Braddock General Hospital, Braddock
Chester County Hospital, West Chester
Chester Hospital, Chester
Children's Homeopathic Hospital, Philadelphia
Children's Hospital, Pittsburgh
Clearfield Hospital, Clearfield
Columbia Hospital, Pittsburgh
Conemaugh Valley Memorial Hospital, Johnstown
Easton Hospital, Easton
Elizabeth Steel Magee Hospital, Pittsburgh
Frankford Hospital, Philadelphia
George F. Geisinger Hospital, Danville
Germantown Dispensary and Hospital, Philadelphia
Hahnemann Hospital, Scranton
Hahnemann Medical and Surgical Hospital, Philadelphia
Hamot Hospital, Erie
Harrisburg Hospital, Harrisburg
Homeopathic Medical and Surgical Hospital, Pittsburgh
Hospital of the Protestant Episcopal Church, Philadelphia
Hospital of the University of Pennsylvania, Philadelphia
Hospital of the Women's Medical College, Philadelphia
J. Lewis Crozer Hospital, Chester
Jefferson Medical College Hospital, Philadelphia
Jewish Hospital, Philadelphia
Lancaster General Hospital, Lancaster
Lankenau Hospital, Philadelphia
*McKeesport Hospital, McKeesport
Medico-Chirurgical Hospital, Philadelphia
Memorial Hospital, Philadelphia
Mercy Hospital, Johnstown
*Mercy Hospital, Philadelphia
Mercy Hospital, Pittsburgh
Mercy Hospital, Wilkes-Barre
Methodist Episcopal Hospital, Philadelphia
Misericordia Hospital, Philadelphia
Moses Taylor Hospital, Scranton
Mt. Sinai Hospital, Philadelphia
Passavant Hospital, Pittsburgh
Pennsylvania Hospital, Philadelphia
Philadelphia General Hospital, Philadelphia
Philadelphia Polyclinic Hospital, Philadelphia
Pittsburgh Hospital, Pittsburgh
Pottsville Hospital, Pottsville
Presbyterian Hospital, Philadelphia
Presbyterian Hospital, Pittsburgh
Reading Hospital, Reading
Robert Packer Hospital, Sayre
Sacred Heart Hospital, Allentown
St. Agnes Hospital, Philadelphia
St. Francis Hospital, Pittsburgh
St. John's General Hospital, Pittsburgh
St. Joseph's Hospital, Lancaster
St. Joseph's Hospital, Philadelphia
St. Joseph's Hospital, Pittsburgh
St. Joseph's Hospital, Reading
St. Luke's Hospital, South Bethlehem
St. Margaret's Hospital, Pittsburgh
St. Mary's Hospital, Philadelphia
St. Vincent's Hospital, Erie
Samaritan Hospital, Philadelphia
South Side Hospital, Pittsburgh
*State Hospital for Injured Persons, Ashland
State Hospital of Middle Coal Fields, Hazelton
State Hospital for Northern Anthracite Coal Regions, Scranton
Washington Hospital, Washington
Western Pennsylvania Hospital, Pittsburgh
Wilkes-Barre City Hospital, Wilkes-Barre
Wills Hospital, Philadelphia
Women's Homeopathic Hospital, Philadelphia
Women's Hospital, Philadelphia
York Hospital and Dispensary, York

50 to 100 beds

Abington Memorial Hospital, Abington
*Rainbridge Private Hospital, Philadelphia
Bryn Mawr Hospital, Bryn Mawr
Carlisle Hospital, Carlisle
Chestnut Hill Hospital, Philadelphia
Children's Hospital, Philadelphia
Children's Hospital of the Mary J. Drexel Home, Philadelphia
Citizens General Hospital, New Kensington
Gynecean Hospital, Philadelphia
Howard Hospital, Philadelphia
Indiana Hospital, Indiana
J. C. Blair Memorial Hospital, Huntingdon
*Jewish Maternity Hospital, Philadelphia
*Joseph Price Memorial Hospital, Philadelphia
*Mercy Hospital, Altoona
Monongahela Memorial Hospital, New Eagle
Montefiore Hospital, Pittsburgh
*Northwestern General Hospital, Philadelphia
Oil City Hospital, Oil City
Palmerton Hospital, Palmerton
Philadelphia Lying-in Charity Hospital, Philadelphia
Preston Retreat Hospital, Philadelphia
*Providence Hospital, Beaver Falls
St. Christopher's Hospital for Children, Philadelphia
St. Luke's Homeopathic Hospital, Philadelphia
St. Vincent's Hospital for Women and Children, Philadelphia
*State Hospital of Nanticoke, Nanticoke
Stetson Hospital, Philadelphia
Suburban General Hospital, Bellevue
West Philadelphia Hospital for Women, Philadelphia

RHODE ISLAND

100 or more beds

*Newport Hospital, Newport
Rhode Island Hospital, Providence
St. Joseph's Hospital, Providence

50 to 100 beds

Memorial Hospital, Pawtucket
Providence Lying-in Hospital, Providence

SOUTH CAROLINA

100 or more beds

Chick Springs Sanitarium, Chick Springs
*Columbia Hospital, Columbia
Florence Infirmary, Florence
*Greenville City Hospital, Greenville
Roper Hospital, Charleston

50 to 100 beds

*Anderson County Hospital, Anderson
Baker Sanatorium, Charleston
St. Francis Xavier Infirmary, Charleston

SOUTH DAKOTA

100 or more beds

McKennan Hospital, Sioux Falls
St. Luke's Hospital, Aberdeen

50 to 100 beds

Lincoln Hospital, Aberdeen
Methodist State Hospital, Mitchell
New Madison Hospital, Madison
*St. Joseph's Hospital, Deadwood
St. Mary's Hospital, Pierre

TENNESSEE

100 or more beds

Baptist Memorial Hospital, Memphis
Erlanger Hospital, Chattanooga
*George W. Hubbard Hospital, Nashville
*Knoxville General Hospital, Knoxville
Memphis General Hospital, Memphis
Nashville City Hospital, Nashville
St. Joseph's Hospital, Memphis
St. Thomas Hospital, Nashville
Vanderbilt University Hospital, Nashville

50 to 100 beds

Baird-Dulaney Hospital, Dyersburg
*Fort Sanders Hospital, Knoxville
Newell and Newell Sanitarium, Chattanooga
Women's Hospital of State of Tennessee, Nashville

TEXAS

100 or more beds

Baptist Hospital, Houston
Baylor Hospital, Dallas
Central Texas Baptist Sanitarium, Waco
Hotel Dieu, Beaumont
John Sealy Hospital, Galveston
Parkland Hospital, Dallas
Providence Sanitarium, Waco
Robert B. Green Memorial Hospital, San Antonio
St. Joseph's Infirmary, Fort Worth
St. Joseph's Infirmary, Houston
St. Mary's Infirmary, Galveston
St. Paul's Sanitarium, Dallas
Santa Rosa Infirmary, San Antonio
*Santa Fe Hospital, Temple
Temple Sanitarium, Temple

50 to 100 beds

All Saints Hospital, Fort Worth
Harris Sanitarium, Fort Worth

Adv. page 58

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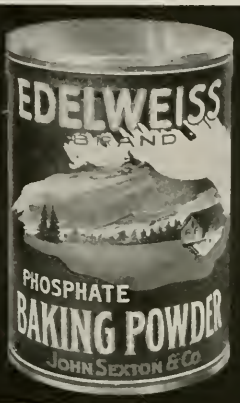

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POINTS

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St. Joseph's Infirmary, Paris

UTAH

100 or more beds

Dr. W. H. Groves' Latter Day Saints Hospital, Salt Lake City
Holy Cross Hospital, Salt Lake City
St. Mark's Hospital, Salt Lake City
*Thomas D. Dee Memorial Hospital, Ogden

VERMONT

100 or more beds

Mary Fletcher Hospital, Burlington

50 to 100 beds

Fanny Allen Hospital, Winooski
Heaton Hospital, Montpelier
*Rutland Hospital, Rutland

VIRGINIA

100 or more beds

*Chesapeake and Ohio Hospital, Clifton Forge
Hospital Division of Medical College of Virginia, Richmond
Norfolk Protestant Hospital, Norfolk
St. Vincent's Hospital, Norfolk
Stuart Circle Hospital, Richmond
University of Virginia Hospital, Charlottesville

50 to 100 beds

Elizabeth Buxton Hospital, Newport News
Jefferson Hospital, Roanoke
Johnston-Willis Sanitarium, Richmond
*King's Daughters' Hospital, Staunton
Lake View Hospital, Suffolk
Lewis-Gale Hospital, Roanoke
*Riverside Hospital, Newport News
St. Elizabeth's Hospital, Richmond
St. Luke's Hospital, Richmond
Sarah Leigh Hospital, Norfolk

WASHINGTON

100 or more beds

Children's Orthopedic Hospital, Seattle
Columbus Sanitarium, Seattle
King County Hospital, Seattle
Maria Beard Deaconess Hospital, Spokane
*Northern Pacific Hospital, Tacoma
Providence Hospital, Seattle
Sacred Heart Hospital, Spokane
St. Elizabeth's Hospital, North Yakima
St. Joseph's Hospital, Tacoma
St. Luke's Hospital, Spokane
St. Mary's Hospital, Walla Walla
Seattle City Hospital, Seattle
Seattle General Hospital, Seattle
Swedish Hospital, Seattle
Tacoma General Hospital, Tacoma

50 to 100 beds

*Minor Hospital, Seattle
*St. Joseph's Hospital, Aberdeen
Virginia Mason Hospital, Seattle

WEST VIRGINIA

100 or more beds

Charleston General Hospital, Charleston
Kessler-Hatfield Hospital, Huntington
Ohio Valley Hospital, Wheeling
St. Mary's Hospital, Clarksburg
Sheltering Arms Hospital, Hansford
*Welch Hospital No. 1, Welch
Wheeling Hospital, Wheeling

50 to 100 beds

*Beckley Hospital, Beckley
*Bluefield Sanitarium, Bluefield
*Chesapeake and Ohio Hospital, Huntington
Coal Valley Hospital, Montgomery
Davis Memorial Hospital, Elkins
*Guthrie Hospital, Huntington
*McKendree Hospital No. 2, McKendree
*St. Luke's Hospital, Bluefield

WISCONSIN

100 or more beds

LaCrosse Lutheran Hospital, LaCrosse
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Mercy Hospital, Janesville
Milwaukee County Hospital, Milwaukee
Milwaukee Hospital, Milwaukee
Mt. Sinai Hospital, Milwaukee
St. Agnes Hospital, Fond du Lac
St. Francis Hospital, LaCrosse
St. Joseph's Hospital, Marshfield
St. Joseph's Hospital, Milwaukee
St. Mary's and Mercy Hospitals, Oshkosh
St. Mary's Hospital, Green Bay
*St. Mary's Hospital, Milwaukee
*St. Mary's Hospital, Superior
Trinity Hospital, Milwaukee

50 to 100 beds

Columbia Hospital, Milwaukee
*Evangelical Deaconess Hospital, Milwaukee
Grandview Hospital, LaCrosse
*Holy Family Hospital, Manitowoc
*LaCrosse Public Hospital, LaCrosse
Milwaukee Children's Hospital, Milwaukee
*Milwaukee Maternity and General Hospital, Milwaukee
*Misericordia Hospital, Milwaukee
St. Elizabeth's Hospital, Appleton
St. Joseph's Hospital, Dodgeville
St. Mary's Hospital, Madison
St. Mary's Hospital, Racine

WYOMING

50 to 100 beds

*Wheatland Hospital, Wheatland

CANADA

ALBERTA

100 or more beds

General Hospital, Calgary
General Hospital, Edmonton
Holy Cross Hospital, Calgary
Medicine Hat Hospital, Medicine Hat
Misericordia Hospital, Edmonton
Royal Alexandra Hospital, Edmonton

50 to 100 beds

*Galt Hospital, Lethbridge
Lamont Public Hospital, Lamont

BRITISH COLUMBIA

100 or more beds

Provincial Royal Jubilee Hospital, Victoria
Royal Columbian Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria
St. Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

50 to 100 beds

*Vernon Jubilee Hospital, Vernon

MANITOBA

100 or more beds

Brandon General Hospital, Brandon
Children's Hospital, Winnipeg
Misericordia Hospital, Winnipeg
St. Boniface Hospital, St. Boniface
Winnipeg General Hospital, Winnipeg

50 to 100 beds

*Victoria Hospital, Winnipeg

NEW BRUNSWICK

100 or more beds

General Public Hospital, St. John

50 to 100 beds

*Chipman Memorial Hospital, St. Stephen
Hotel Dieu, Campbellton
Hotel Dieu, Chatham
Miramichi Hospital, Neweastle
Moncton Hospital, Moncton
St. John's Infirmary, St. John
Victoria Public Hospital, Fredericton

NOVA SCOTIA

100 or more beds

St. Joseph's Hospital, Glace Bay
Salvation Army Maternity Hospital, Halifax
Victoria General Hospital, Halifax

50 to 100 beds

Aberdeen Hospital, New Glasgow
Children's Hospital, Halifax
*General Hospital, Glace Bay
Highland View Hospital, Amherst
*St. Martha's Hospital, Antigonish

ONTARIO

100 or more beds

Carleton County Protestant General Hospital, Ottawa
General Hospital, Kingston
General Hospital, Toronto
Grace Hospital, Toronto
Hamilton City Hospital, Hamilton
Hotel Dieu, Kingston
McKellar General Hospital, Ft. William
Ottawa General Hospital, Ottawa
St. Joseph's Hospital, Hamilton
*St. Joseph's Hospital, London
St. Joseph's Hospital, Port Arthur
St. Luke's Hospital, Ottawa
St. Michael's Hospital, Toronto
Sick Children's Hospital, Toronto
Victoria Hospital, London
*Western Hospital, Toronto

50 to 100 beds

*General Hospital, Brockville
*General Hospital, Sault Ste. Marie
Niagara Falls General Hospital, Niagara Falls
*Nicholls Hospital, Peterborough
*St. Francis Hospital, Smith's Falls
*St. Joseph's Hospital, Peterborough
*St. Vincent de Paul Hospital, Brockville
*Smith's Falls Public Hospital, Smith's Falls
*Welland County Hospital, Welland
Wellesley Hospital, Toronto
Women's College Hospital, Toronto

PRINCE EDWARD ISLAND

50 to 100 beds

Charlottetown Hospital, Charlottetown
Prince Edward Island Hospital, Charlottetown

QUEBEC

100 or more beds

Children's Memorial Hospital, Montreal
General de St. Vincent Hospital, Sherbrooke
Hotel Dieu, Montreal
Jeffery Hale's Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Royal Victoria Hospital, Montreal
Sainte Justine Pour Les Enfants, Montreal
*Western Hospital, Montreal

50 to 100 beds

Montreal Maternity Hospital, Montreal
*Sherbrooke Hospital, Sherbrooke

SASKATCHEWAN

100 or more beds

Grey Nuns Hospital, Regina
Regina General Hospital, Regina
St. Paul's Hospital, Saskatoon
Saskatoon City Hospital, Saskatoon

50 to 100 beds

Holy Family Hospital, Prince Albert
*Notre Dame Hospital, North Battleford
*Prince Albert Municipal Hospital (Victoria Hospital), Prince Albert
Providence Hospital, Moose Jaw

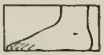
Adv. page 60

A New Idea in Shoes that is 2000 years old

IN the days of old Rome the people wore sandals, designed primarily to support the foot as Nature requires. The sandal afforded a foot-length support, just like going "bare-footed." There is no record of foot weakness or discomfort in those early days.

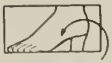
But Civilization, in its eagerness to secure more stylish apparel, adopted the heel. This marked the end of the natural foot-length support. The foot arch was allowed to sag, subject to a constant strain. Today ninety percent of all women suffer with their feet largely because the arch is not properly supported as Nature planned.

The Arch Preserver Shoe—a new idea in shoes that is 2,000 years old—has revived the sandal comfort and healthfulness. Its concealed, built-in arch bridge gives the foot the same support as when walking "barefooted"—keeps the arch from sagging while the heel is raised from the ground—in the smartest shoes that Fashion knows.



Nature plans that the foot rest on heel, ball and outside arch.

Civilization demands that heel and arch be raised.



The Arch Preserver Shoe satisfies both Nature and Civilization.

The Arch Preserver Shoe is the *only* shoe of its kind because its distinctive construction is *patented*. To satisfy both Nature and Fashion you therefore must be sure that you are buying the genuine Arch Preserver. This trade-mark on the sole and lining is your guarantee.

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Every woman who wants to stay young should read this booklet, "The Feet and the Face." It shows how much the feet have to do with facial beauty and tells how to care for the feet if one would retain the charm of youth. Send coupon today. Also ask for name of dealer or phone the "Tel-U-Where" Bureau in your city.

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Please send postpaid your booklet 84, "The Feet and the Face," and name of dealer.

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FOREIGN CORRESPONDENCE

WOULD HAVE BRITISH HOSPITALS PART OF STATE MEDICAL SERVICE

By Our London Correspondent

THE hospital question is still pending in this country and even an approach to a settlement seems far away. As a matter of fact those responsible for the management of these institutions are on the horns of a dilemma. While they recognize that drastic changes must be made, they are wedded to the voluntary system and are unwilling to take steps which may tend to impair it or imperil it. The medical profession dreads state control which might, and probably would, place its members in the power of the approved societies which are politically influential, while the medical profession is practically impotent in this direction. On the other hand it is plainly evident that strong efforts must be made at once to render the hospitals financially secure and various schemes have been mapped out, some of which have been put into practice to attain this end.

A conference between the Voluntary Hospitals Commission and representatives of the local voluntary hospital committees was held recently at the Ministry of Health. At this conference several important phases of the hospital situation were discussed by experts and plans suggested to relieve the tension. The chairman, Lord Onslow, explained that the object of the government, of the commission and of the local committees was to maintain intact the voluntary system and the minister of health has asked him to lay stress on this fundamental consideration. Their first duty was to administer the grant of $2,500,000 voted by the government. For this purpose the local voluntary hospital committees had been established.

In London the duties of a local committee had been undertaken by King Edward's Hospital Fund. In no case had the grant exceeded more than one-half of the estimated deficit on maintenance account for the year 1921. The estimate of Lord Cave's committee of the deficit of the London hospitals was $2,315,000. King Edward's Fund had reported, however, that the actual deficit was $1,600,000. In London a combined appeal had been launched with marked success. In the rest of the country fifty-four voluntary hospital committees were operating, and there were only eight areas in which committees had not yet been established. As regards the bulk allocation of the total sum at the commission's disposal, as between London and the provinces, it had resolved, subject to a final adjustment of the figures, that $1,125,000, including the amounts already voted, be appropriated to London, and $1,375,000, including the sums already voted, to the remaining areas. The information before the commission went to show that the cost of maintenance was declining, while income was being maintained and in many cases rising. In the discussion which followed Mr. H. N. Crouch spoke of the difficulties in securing coordination and economies because the hospitals were apt to regard themselves as isolated units. The lack of system tended to waste in accommodation and in the medical services. He proposed the following resolution: "That the voluntary hospitals' areas be so regrouped that each area constitute a suitable unit in which to make the attempt to effect coordination between existing hospitals and gradually to create a complete and properly conducted hospital system on a voluntary basis.

With regard to the difficulties which local committees experience in obtaining information on the methods pursued in other areas Mr. Davis, Manchester, suggested that the commission should issue a pamphlet on the methods which have secured the high standard of excellence in some of the best hospitals, giving particulars of the control and administration of the hospital, how it reaches the public, and how the public regard it. Speaking of the need for systematic collection from employes and workers, he stated that the public was anxious to maintain voluntary hospitals; the difficulty was to create facilities through which help could be given. In particular the crux lay in getting to the employe through the employer, who did not always facilitate entree to his works. He suggested that the commission should approach the Federation of British Industries, and urged that steps should be taken to obtain the sympathy of labor leaders and to secure an expression of opinion from them that they are not averse from the payment of weekly contributions by working people.

At about the same time at which this conference was held the question of hospitals and state medical service was discussed at a conference of the Social Democratic Federation held in London. Dr. Illis Morgan gave an address on the matter in which he advocated that hospitals should be part of the state medical service and he asked what the voluntary philanthropic efforts have attained. For six months they had had a raging, tearing propaganda in aid of a combined appeal for the hospitals; all sorts of means had been devised to wheedle, cajole, coax and swindle money out of people's pockets and with

Adv. page 62

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what result? They clamored for $2,500,000; they had obtained $1,500,000 of which $150,000 had been swallowed up in expenses. The state had done nothing to deal with the underlying causes of disease. The hospitals were the only link in the chain of medical service which was not provided by the state, and which therefore could not be joined up with the others. Those who required special treatment, for which they could not afford to pay, had to go as suppliants and not as having a rightful claim to hospital treatment.

Questioned as to whether the cost of making the hospitals part of the public service would not be prohibitive and whether coordination with the other services would not be almost impossible, Dr. Morgan said his view was that a properly arranged medical service, eliminating the present overlapping, could be obtained at little or no increased cost to the ratepayers. He would reserve the hospitals for casualty cases; and cases requiring special skill and attention should be sent to consultants by the outside general medical service. He would do away with the general out-patient departments. He would also do away with the whole poor law service, and would link up the infirmaries with the hospital service.

The cases which now filled up the out-patient departments of the hospitals and these treated in the poor law infirmaries he would deal with by an extension modification of the national insurance system. Under the latter the working man for the first time would choose his own doctor; under the old club system the local committee selected his doctor. Another great merit of the scheme was that the doctor working in the poorer districts to alleviate the sufferings of those around him was at last assured of a decent remuneration for his labors. If they linked up a modified rational insurance scheme with the special treatment to be obtained at the hospitals, convalescent homes, sanatoriums and the like, the result to national health would be more satisfactory than it was at the present time.

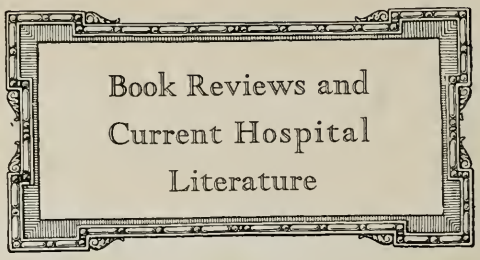
Without discussion the conference passed a resolution, viewing with regret the present unfortunate position of the hospitals, declaring that it demonstrated the failure of voluntary subscriptions to provide the necessary hospital accommodation, and calling upon the labor party to press "for the immediate socialization of this valuable institution into the service of the nation."

It will be observed that views are very conflicting with respect to the best means to be employed both to place the hospitals on a sound financial basis and at the same time to give the most efficient service to the public.

BOOKS RECEIVED

PHYSICAL DIAGNOSIS. By W. D. Rose, M.D., Lecturer on Physical Diagnosis and Associate Professor of Medicine in the University of Arkansas; Visiting Physician, Little Rock City Hospital, Baptist Hospital, and St. Vincent's Infirmary, Little Rock, Ark. Third edition, with 319 illustrations. C. V. Mosby Company, St. Louis, 1922.

DISEASES OF THE THYROID GLAND. By Arthur E. Hertzler, M.D., F.A.C.S., Professor of Surgery in the University of Kansas School of Medicine; Surgeon to Halstead Hospital, Halstead, Kan.; Surgeon to St. Luke's Hospital and St. Mary's Hospital, Kansas City, Mo.; and to Provident Hospital, Kansas City, Kan. With a chapter on *Hospital Management of Goiter Patients* by Victor E. Chesky, A.B., M.D., Associate Surgeon to Halstead Hospital. With 106 original illustrations. C. V. Mosby Company, St. Louis, 1922.



A HISTORY OF THE NATIONAL TUBERCULOSIS ASSOCIATION

Or The Anti-Tuberculosis Movement in the United States. By S. Adolphus Knopf, M.D., National Tuberculosis Association, 370 Seventh Avenue, New York, 1922.

Seventeen years of organized warfare against tuberculosis are recounted in Dr. S. Adolphus Knopf's volume, "A History of the National Tuberculosis Association." In it are narrated the association's slender beginnings, its early problems and the development of its extensive educational campaign and local organization program. An entire chapter is devoted to the Christmas seal sale and another to the Framingham Community Health and Tuberculosis Demonstration at Framingham, Mass. State associations each get ample space to relate their achievements, and notes on the seventeen annual meetings of the national body are included.

Of genuine interest in the book are the biographies of some fifty officers of the association since its founding. These include biographical sketches of its honorary vice presidents from Grover Cleveland to Warren G. Harding, in addition to regular officers, among whom have been most of the great leaders in tuberculosis work in this country. The biographies are for the most part inspiringly written. Halftones of the various officers accompany the biographical notes.

In appendices to the volume attention is paid anti-tuberculosis work done during and after the World War in the offices of the surgeon generals of army, navy and public health service, the publications of the national association, and comprehensive bibliography of the author, Dr. Knopf.

OBSTETRICS FOR NURSES

By Joseph B. De Lee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School; Obstetrician to the Chicago Lying-In Hospital and Dispensary. Sixth Edition, entirely reset.

This book which is well and favorably known has been thoroughly reviewed and brought up-to-date. Several more pages are devoted to the operation of Ceasarean Section, and the methods of the Chicago Lying-in Hospital have been more fully presented. The place of honor is still held by the old and tried methods which enable nurses to meet the emergencies in private homes, which is an inevitable part of obstetrical work.

New illustrations and several new pictures are valuable additions.

[1]W. B. Saunders Company, Philadelphia and London, 1922.

PHYSIOLOGY AND BIOCHEMISTRY IN MODERN MEDICINE. By J. J. R. MacLeod, M.D., Professor of Physiology in the University of Toronto, Toronto, Canada. Assisted by Roy G. Pearce, A. C. Redfield and N. B. Taylor and by others. Fourth edition. With 243 illustrations. C. V. Mosby Company, St. Louis, 1922.

Adv. page 64

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XIX *December 1922* No. 6

"'TWAS THE NIGHT BEFORE—"

By FLORENCE LEININGER, Colorado Springs, Colo.

ROOM Two Hundred had been transformed from a hospital cell into a Christmas garden, with the tree—a tiny, graceful spruce—mounted on a table at the foot of the high white bed. In spite of her twenty years, the girl on the bed looked very much a child, with her closely-bobbed brown curls, her softly-pink cheeks, and her frilly bed-jacket sprinkled with rosebuds.

The door opened to admit Miss Breen, the hospital social service worker, carrying a wreath of trailing kinnikinick for the window.

"Oh, Miss Breen, you've been *too* good to me," exclaimed Vivian Craig. "Our nurse has been so busy that she couldn't have found any extra time for me, and you have made it possible to have Christmas just as I want it. You see," the voice became confidential, "this is probably the most important Christmas in my life—except, of course, last Christmas. You know it was last Christmas, at nine o'clock in the morning, that I met Glenn; and after we were engaged we promised each other that we'd always celebrate together that hour Christmas morning.

The door opened to admit the hospital social worker carrying a wreath of trailing kinnikinick for the window.

"Did I ever tell you just how I happened to meet him? I was going out of Grandmother's yard to carry a basket to the family next door. Just in front of the gate was a huge snowdrift and I was looking to see how I could get over it, when some one stepped up and took me under his arm like a bundle and lifted me over. When I got my feet on the sidewalk again I looked up, and there was the *handsomest tallest* boy I had ever seen. He was laughing at me. He has a beautiful smile. He told me he was spending his Christmas holidays in our town, and I invited him to come and call on Grandmother before he went away. He came that very evening. He had to get acquainted in a hurry because Glenn was to go back to college the day after New Year's."

Vivian was silent a moment and then added softly, "He came to visit me in June, after his graduation; it was then that we agreed we'd always celebrate our Christmas mornings together. So you see, Miss Breen, why it has become an important day."

Ellen Breen had been busy with holly wreaths and Christmas bells during Vivian's recital, but

at this naive conclusion she stopped to smile indulgently at the happy face. Did this fluffy child suppose that she, Ellen Breen, had lived thirty years without coming to know that most folks have, recorded in their secret hearts, anniversaries of far more importance than those listed on the calendar?

Ellen had hers. She had sent Jud Holton to the war without marrying him. She had been unwilling just then to risk an interruption of her hospital work, and Jud had gone away with a good deal of bitterness. When he returned two years later he was restless, unsettled. He did not urge marriage, and finally went with some other engineers to South America. Since then there had been no letters. An occasional post card came to Ellen, bearing neither message nor Jud's address; the postmark was always different.

Ellen tried to forget the hurt of it, and the loneliness, by putting her whole being into her work. She was loved and depended on in the hospital.

In addition to her regular duties, Ellen had undertaken to make a cheery Christmas for several of the patients who might otherwise be lonely. And for Vivian Craig she had spent many hours. The girl had been radiant with joyous plans ever since her doctor had agreed that Glenn might visit her. And Ellen, in spite of the way that Vivian's anticipation intensified her own loneliness, was unwilling to see her disappointed over any smallest detail.

Now, on Saturday morning—Christmas would come on Sunday—everything was completed. Glenn's train was due that evening. He would not see Vivian until nine o'clock on Christmas morning, when the nurse would serve breakfast for two beside the gay little tree.

It had been snowing and blowing all of Friday night, and this morning the drifts were assuming formidable proportions. The spirit of the season—that something which causes us to forgive alike the weather and our debtors—had taken possession of the people on the streets, and they were battling merrily with the rapidly-deepening drifts. But by noon the holiday crowds were being forced off the streets and sidewalks. Shovels and snowplows were unable to keep pace with the storm, and people struggled to get home before that became an impossibility.

Ellen Breen watched the snow anxiously. She knew that Glenn's train should arrive at Exeter Junction—ten miles away—at three that afternoon. There he was to wait a couple of hours for the branch line train which would bring him the rest of the journey. Ellen felt sure that the main-line tracks would be kept clear; but the branch from the Junction, with its two trains a day—that was different.

At frequent intervals during the afternoon Ellen telephoned about trains. The replies were always vague and never reassuring. At four o'clock a telephone call came for her; Glenn Hill, at Exeter Junction. Was this Miss Breen of whom Vivian Craig had written him? And would she deliver a message to Vivian for him? His train had reached the Junction half an hour ago, and there he learned that no train was apt to run on the branch road in the next twenty-four hours. He had telephoned every garage in the town, but no one would agree to come for him before noon of the next day. He had tried to get some farmer around the Junction to drive him in, but could find none who would attempt the trip that night. Of course—here Glenn laughed a litte to show of how slight consequence this point was, but Ellen Breen caught the quiver in his voice which told her that it was of very great consequence indeed—he could manage to get in next day, but he had really wanted to be there by nine o'clock in the morning. He'd still try, but there seemed little chance to make it, so would Miss Breen please prepare Vivian for the likelihood that he would be delayed? She told him she would, and hung up the receiver. And then Ellen Breen felt an impulse to tears. She hadn't known until that moment how very much she wanted the girl to have her day as perfect as she had dreamed it.

A moment later Ellen opened the door of Two Hundred. "Vivian, have you been watching the snow? All the roads are drifted full."

Vivian laughed happily. "How lovely!" she cried. "That's real Christmas weather."

Ellen looked at the eager girl, so secure in her happy plans, and shut her lips hard on the message she had come to deliver. She went out and sought the head nurse. After a few minutes of consultation the two women decided that Vivian should not be told that night. She was recovering from a hard siege of typhoid fever, and could not afford to spend any of her returning strength in grieving. As Ellen started away she turned back to say, "Tell her nothing before nine o'clock in the morning."

Exactly half an hour later Ellen, in riding clothes and an extra coat, stood in the office of the Kenwood Stables, where she had been a frequent renter of riding-horses. "Mr. Winter," she said, "will Barney, the horse I rode so much last fall, carry double?"

"I think so, Miss Breen."

"Have you a man who would ride him to Exeter Junction tonight, and back with a passenger?"

"I'm sorry, but I'm afraid not, Miss Breen."

"Then will you let me take him?"

"I will if you intend to ride him yourself."

"I do," answered Ellen. "Have him ready as quickly as possible. Give me a saddle large enough that I can spread a blanket over it to wrap my legs. Then give me a lantern and another blanket, and put this thermos bottle and a feed of oats into a saddle bag."

Mr. Winter took the bottle and called one of his men. He asked no questions. People did not usually question Ellen Breen when she spoke in that determined tone.

Before ten minutes had passed Ellen was atop of Barney, with Mr. Winter adjusting her stirrups and tucking in the blanket. She headed the horse country-ward, in the direction of Exeter Junction. The snow had ceased to fall; the wind was going down; and a rosy glow in the western sky promised that the storm was over. Ellen's heart was lighter than it had been for several hours; Barney knew her, and he seemed to catch her mood. The air was not extremely cold, though with the sky clearing it was apt to grow colder. On horseback it was seldom necessary to wade the deepest part of the drifts. Ellen was an inveterate walker and rider and knew every bit of the road thoroughly. Often there were stretches of a quarter of a mile where the road was swept clean of snow. Again the drifts were high and wide, but there was almost always a way to skirt them, and Barney never missed it.

When they had been on the road an hour, and daylight was all but gone, Ellen saw, with a gasp of delighted surprise, that they were to have moonlight for the rest of the journey. This was more than she had thought of hoping for.

She halted Barney and called, "Are you Glenn Hill?"

More than once the cheerful light from farmhouse windows tempted her to go in and rest, but that was not a part of Ellen's plans. She munched a bar of hard chocolate and ate some raisins. She talked friendlily to Barney, who made eloquent gestures with his ears and nose.

At ten o'clock Ellen sighted a figure coming toward her in the road. Coming closer, she saw that it was a man, very tall. Suddenly suspecting, she halted Barney and called, "Are you Glenn Hill?"

"I am," came the surprised answer.

"Well, I'm Miss Breen. I rode out here to get you. Where are you going?"

"I was going to try to walk to town. I saw it was good moonlight, and it seemed the only way to get there."

"Boy, can't you see that that moon will be gone in half an hour? More than that, you don't know the road. There are a dozen places where you could make the wrong turn. Come back to the Junction with me, take care of my horse, and let me rest a few hours. Then we'll light the lantern and start back. Barney and I have made a path which will be good unless the wind comes up again."

Glenn's amazement left him speechless. He turned and fell in behind the horse. He had left the station only a few minutes before.

When Ellen tried to dismount, she realized how cold and tired she was. Her legs threatened to refuse to hold her. Inside the dingy waiting room she drank a cup of the strong coffee she had brought, and stretched out on the long seat, with one of the blankets for a covering.

When, according to instructions, Glenn said, "Four o'clock, Miss Breen," she sat up at once,

and declared that she was entirely rested.

Glenn was looking sober. "Miss Breen," he said, "I've been thinking of what a brick you are to have made this trip. Now I want you to stay here, or go to the nearest farmhouse, and wait until I can send a car for you."

"Not on your life," said Ellen Breen. "I chose to do this thing, and I'm going to see it through. We'll finish this coffee; then you get Barney around. We haven't any time to waste. He'll have a double load going back. We'll hardly need the lantern, the way those stars are shining."

After they were started Glenn said, "I wonder if it seems ridiculous to you, this needing to be there by nine o'clock."

"Not a bit," declared Ellen. "I understand it perfectly. I wouldn't think much of you if you hadn't tried to get there."

The two asked each other occasional questions, but for the most part the ride was made in silence. Once Ellen said, "Boy, fold up those long legs of yours while we're going through a snowdrift. They impede Barney's progress."

Glenn laughed, and obeyed. He hadn't been called "Boy" like that for some time, but from Ellen Breen he didn't mind it.

Just as the sun peeped over the horizon, each remembered to wish the other a merry Christmas. It was eight-thirty when they finally rode in at the Kenwood Stables. Mr. Winter met them with, "Congratulations, Miss Breen. If it had been any other woman I'd have said she wouldn't make it."

Ellen sent Glenn with Mr. Winter for a brushing and a change of collar. When he returned to her, smiling and ready, she understood exactly how he had appeared to Vivian a year ago. "Three blocks to walk," she said briefly. She was aching in every inch of her.

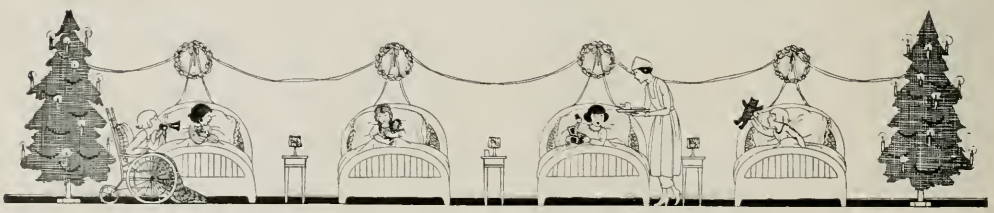
As they stepped off the elevator on the second floor of the hospital, at five minutes of nine, Glenn caught Ellen's hand impulsively. "I mean to show you how grateful I am, some day," he muttered.

Ellen patted the hand. "That's her door," she said; "go on in." She walked toward the door of her own little office-sitting room, on down the hall. Now that the job was done, it seemed to her she could not move another step. Her door stood open and she could hear a fire crackling in the grate. That was good. Her mind was filled with a vision of getting off her wraps and stretching out on the couch before the fire. As she half-staggered through the doors, fingers tugging at buckles, a pair of strong arms took possession of her, guided her to the couch, and then held her close.

Ellen took one long look; whispered, "Jud"; and nestled against his shoulder. Comfort and warmth and joy surged through her, a reviving flood.

A group of nurses were singing carols on the stairs. At "Peace on earth—" Ellen lifted her head. "Oh, Juddie," her arms went tight about his neck, "that's just what this is. I don't begin to understand how it happened, and right now I don't even care to wonder. All I know is that if I hadn't got that long-legged boy in here by nine o'clock, I wouldn't dare to be half this happy now."

Neither did Jud understand; but he knew this was not the hour for explanations. In silence he caressed the head which had found its way back to his shoulder.



THE MARY IMOGENE BASSETT HOSPITAL—A GIFT TO COOPERSTOWN

By WILLIAM G. SOEKLAND, Superintendent, Mary Imogene Bassett Hospital, Cooperstown, N. Y.

THE Mary Imogene Bassett Hospital is located in Cooperstown, N. Y., that quaint old village made famous by James Fenimore Cooper in his "The Deerslayer" and "The Pioneer." A grandson of that noted author is now a member of its board of directors.

The hospital group is situated a stone's throw from the Susquehanna River and about four city blocks from its source, which is Otsego Lake. The buildings face the river and there is a beautiful view down the valley through which the stream flows.

This splendid institution was made available for the care and treatment of the sick in the vicinity through the generosity of Mr. Edward Severin Clark. A small hospital operating in Cooperstown had long since reached its capacity, so on June 29, 1922 its medical, surgical and nursing personnel and the nurses' training school were taken over as a nucleus for the new institution. On the same date the buildings were opened for active operation, with 100 beds available for the acceptance of all cases (regardless of race or creed), excepting those suffering from mental disorders, from tuberculosis or from diseases resulting from the excessive use of harmful drugs.

The Tower, Mary Imogene Bassett Hospital, Cooperstown, N. Y.

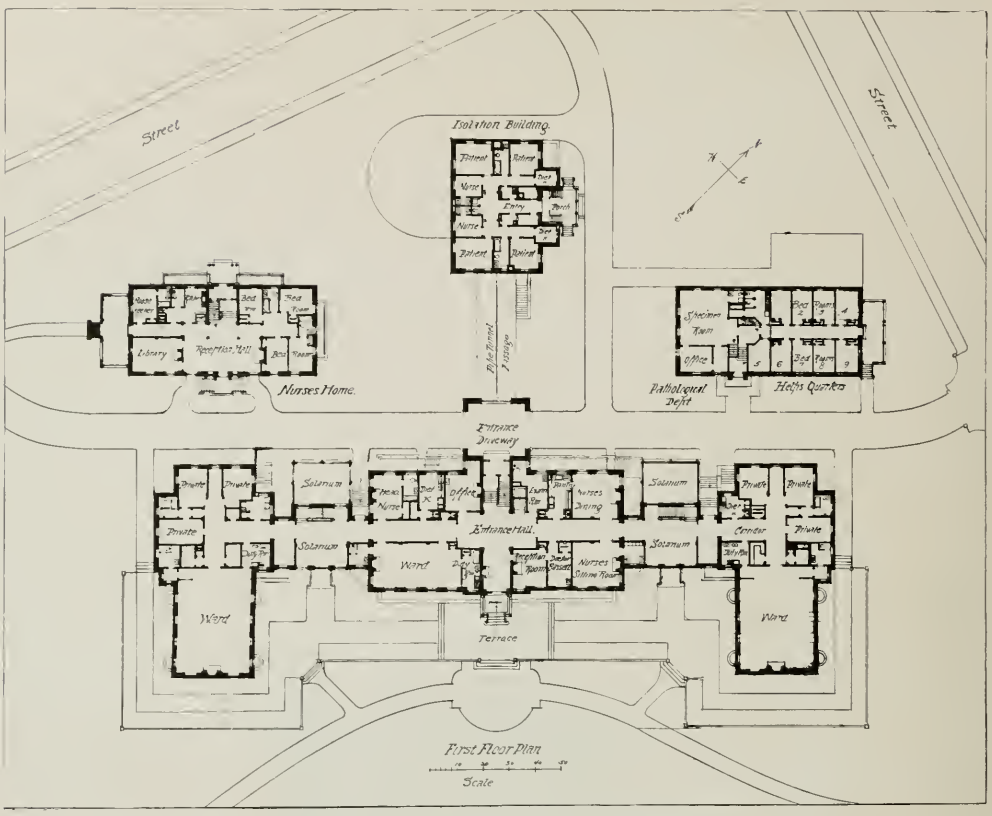
The hospital was named for Dr. Mary Imogene Bassett, who for many years had been one of the foremost physicians of this section. Dr. Bassett was chief of the medical and surgical staff and head of the obstetrical service, until her death which occurred suddenly on October 21, 1922.

The hospital group consists of four buildings; the main structure, which contains the wards, private rooms, administrative offices and all services, excepting the pathological laboratory; the pathological laboratory building which contains the laboratory in one half and helps' quarters in the other, while in the basement are found a well equipped modern laundry, a hospital sterilizer and an incinerator; the nurses' home building which accommodates twenty-four nurses (a separate room for each) and in the basement of which, half above ground level, are located the class and demonstration room, dietetic laboratory and demonstration kitchen; and lastly the isolation building, containing twelve private rooms and a dormitory. The private rooms occupy the first and second floors and the dormitory the third, all being arranged so as to afford complete isolation in suites of two or more rooms or for an entire floor. In the basement of this building (but not connected by doors or stairway with the upper floors) is a central heating plant which furnishes steam for heating and other purposes to the entire group and hot water for the main and isolation buildings. The other two buildings have an auxiliary water heater in each.

The design of the buildings is colonial; the material is stone, taken the most part from older buildings in the vicinity purchased for that purpose, and the remainder from the nearby hills. The construction is fireproof throughout, excepting single doors and windows. Corridor doors are all double acting and fireproof. Mr. Frank P. Whiting was the architect.

There is an automatic electric elevator (sufficient in size to accommodate a wheel stretcher) running from basement to third floor. This elevator is located in the center of the main building and at the side of it is a marble staircase. There also are additional staircases from basement to third floor at each solarium entrance from the corridors or loggias.

The electric current for power and light is furnished from outside sources but as a safety meas-

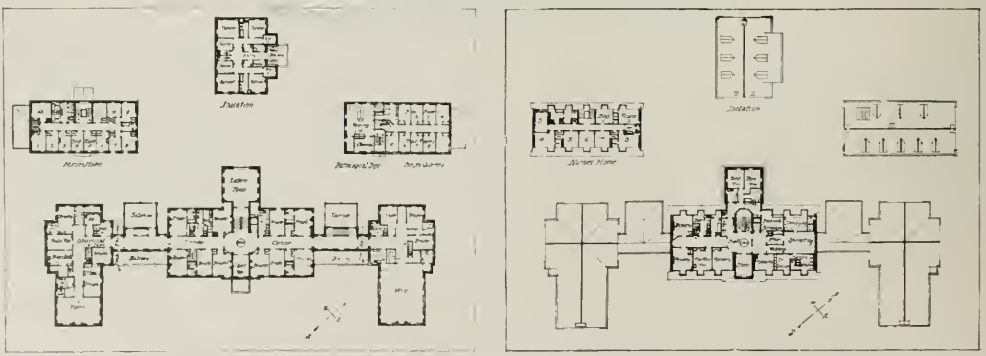


First floor plan and general layout of the hospital buildings

ure there is an auxiliary lighting system installed in the hospital operated from storage batteries which would furnish light for a period of six hours.

A telephone system connecting outside lines provides service to each office, ward, department, and private room. In addition to this service there is a local system which connects the main kitchen with each diet kitchen.

The wards and private rooms are equipped



Second and third floor plans of the Bassett Hospital

with an efficient signal system which not only signals by the light over door and sounding buzzer but also announces the call in the utility room, the diet kitchen, at the nurse's station and at the supervisor's station.

Assembly Room With Covered Entrance

In the rear of the main front entrance at a level between the first and second floors is a lecture or assembly room leading to which is a covered entrance for patients and visitors. This driveway serves also for delivery conveyances and is the only roadway approaching the buildings within the hospital grounds. The front entrance is reached by gravel walks from the street some distance away.

The hospital grounds cover some ten or more acres and are set out with more than 2,000 shrubs. Climbing vines have been planted at intervals along the base of the walls of each building and that part of the grounds not taken up by flower gardens is covered with beautiful grass.

The center of the main building has a solarium at either end on the first and second floors, and beyond these are located the wings, in each of which are a ward and three private rooms with diet kitchen, utility and bathrooms serving that section. A special feature is the diet kitchens, each being so located that twenty-six steps is the longest distance to be covered; only one door is to be opened, which means the tray reaches a patient's bedside thirty seconds after being served from the steam table.

Each diet kitchen is equipped with a combination steam heated table and a double burner gas grill. There are also facilities for attaching electrical equipment if desired. The dish cabinet units, also cupboards and sink units are all of white enameled steel. White enamel tray racks are furnished throughout and each kitchen has a medium-sized refrigerator.

Each ward and most of the private rooms have fireplaces, and between wards and the center of main buildings are fresh air cut-offs or cross corridors, ventilated by transoms over the windows. There is also a fresh air room between each toilet and ward proper. This special arrangement combined with the way the building is spread out does away with the necessity of artificial ventilation of any kind.

There are two male wards and two female wards, one of the latter being a maternity ward with two delivery rooms and nursery for eight babies. There is also a children's ward in center of building on first floor, while above on the second floor is situated the private room section consisting of ten rooms.

On the third floor center is located the surgery with general and minor operating rooms, a fracture room, surgeons' dressing and scrub-up rooms, an etherizing room, sterilizer room and an instrument and surgical dressing storeroom. On this floor also are three recovery rooms and a private room with consultation and rest room adjoining.

The general kitchens and dining rooms for nurses, students, and employes are located in the basement. Diet kitchens on each floor above are served by dumbwaiters from basement.

In the basement are located the provision storeroom, the general medical and surgical supplies room, drug room, pharmacy, linen room, locker room, hydrotherapy room and the mortuary. There is also an x-ray service located in one wing of the basement which is one of the most completely equipped of its kind that can be found anywhere. This service includes a large operating room with dressing, developing, steroscopic and plate storage rooms adjacent to and opening

Exterior of main building, Mary Imogene Bassett Hospital. The grounds are beautifully landscaped

into it; also the record room and office of the roentgenologist.

The interior color scheme of the entire building is one of the soft tones, each corridor and room being just a bit different. The general color is buff and a very pale pea green. Nowhere is there to be found the glaring white effect excepting in the white tiled utility and bath rooms. The general operating room has a gray tile floor and walls the same, up to the height of an average person.

The private rooms are furnished with wood furniture and special effort has been made to lend a "homelike" effect to all the surroundings.

The hospital is governed by a board of directors consisting of five members. The sick in hospital are treated by physicians and surgeons composing a visiting staff, and while the wards may be considered closed, the private rooms are open to all members of the medical profession.

The administrative organization is under the supervision of a superintendent, who is responsible to the board of directors for the administration of the entire institution. He controls all departments, officers, employes and patients, except so far as concerns medical treatment. The organization is divided into departments under the following heads: the superintendent of nurses and supervisor of the school for nurses; the dietitian; the housekeeper; the steward; the pharmacist; and the supervisor of maintenance and engineering.

Entrance hall, Mary Imogene Bassett Hospital

Staircase to lecture hall, Mary Imogene Bassett Hospital

The hospital departments are divided as follows: wards; semi-private rooms; private rooms; operating, examining and dressing rooms; hospital laboratories; roentgen-ray department and the hydrotherapy service.

CORNERSTONE OF JAMES WHITCOMB RILEY MEMORIAL HOSPITAL LAID

Indiana paid tribute on October 7 to the memory of the Hoosier "children's poet," James Whitcomb Riley. On the anniversary of his birth the cornerstone of the Riley memorial, the James Whitcomb Riley Hospital for Children, was laid. The hospital will be a $2,000,000 institution, erected through contributions from persons in all sections of the state, and will be devoted exclusively to the care and treatment of sick and crippled children of Indiana.

Thomas R. Marshall, former vice-president of the United States and an intimate friend of the poet during the latter's life, and Governor Warren T. McCray were the principal speakers, the actual laying of the cornerstone and the attendant ceremonies being performed by school children.

The hospital, when entirely completed, will cover more than twelve acres of ground and will be surrounded by a convalescent park of more than eighty acres. Friends of Riley and lovers of his poems have contributed the funds for the building.

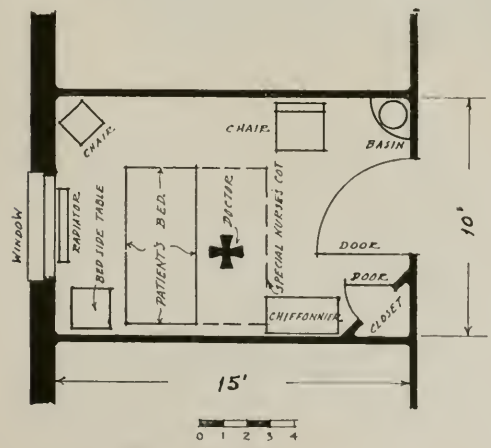
TECHNIQUE IN PLANNING PRIVATE ROOMS

By RICHARD RESLER, Resler & Hesselbach, Architectural and Consulting Engineers, New York

IN VIEW of the many sizes and shapes of private rooms both square and oblong, which one observes during hospital investigations of existing buildings and plans, it would seem that there must be one type which in actual practice embodies superior technique, not only for the patient but for the medical and nursing professions.

With this in mind the writer will attempt herein to present a small private room with its equipment all arranged to give compactness and to embody the requisites necessary for convenient and efficient examination of the patient.

The fixture that is of paramount importance and requires the greatest floor area is the bed. In the first place the bed should be near the window so that the patient may see what is happening outside. It is generally agreed among members of the medical profession that there is a certain therapeutic value in providing the patient with such an outlook. However, this provision does not conclude the requirements, as accessibility for convenient and unobstructed examination and handling of the patient both by the nurse and the doctor is a factor of great consequence. During the writer's extensive investigation and inquiries among a large number of medical and surgical men it was found they agreed almost unanimously that right-handed examination of their patient while abed was most desirable. It was also ascertained that the location of the source of light or window should be directly opposite the examiner, so as to obviate the casting of shadows on the field of examination. In other words the doctor's position should be on the right-hand side of the patient, with the window on the left. The accompanying diagram indicates the general arrangement of such a private room.



Private Room

Such being the case, it appears that the foremost requisite in the room has been definitely located. The other equipment in this room, although of a secondary nature, must be judiciously located for compactness. So that the patient may see outdoors while abed, it is necessary to install the window still lower than is usual. To obviate the danger of anyone's falling out of the window a plate glass panel in a metal frame should be located above the sill to a height of about three feet above the floor. This panel has the dual function of a guard and ventilator when the window is raised slightly from the bottom. With the bed located as shown on the diagram it is necessary, in order to permit passage at the foot, to allow a minimum distance of three feet between the bed and the wall. As the bed is not always tight against the wall, and allowing space for the use of bed raisers, which on a radius extend the foot of the bed both upwards and outwards, the working distance of about two feet six inches passage width is then available.

A space of three feet from the window to the bed is necessary to accommodate a bedside table and permit access to the wall plugs, etc. The bed itself is three feet wide and a space of three feet should be provided for a special nurse's cot and an additional three feet allowed for a chiffonnier, all of which requires a space of approximately twelve feet. With a closet which should average from two to three feet in width, the entire room develops a minimum length of from fourteen to fifteen feet and a width of nine feet six inches to ten feet.

It is highly desirable to extend the doors and windows up to the ceiling and equip them with reasonably sized transoms. The most practical and foolproof method of operating them is the old fashioned metal transom adjuster, controlled by a thumb catch set at a height of five feet above the floor.

Such a room presents space for one straight chair, a rocker or Morris chair and a basin as shown. Although compact it is evident that the passage is free and unobstructed, and that the prime requirements have been conformed to. The nurse's cot is rolled under the patient's bed when not in use which permits visitors to be seated beside the patient.

CLEVELAND WOMEN'S ENTERPRISE IN THE CARE OF CONVALESCENT CHILDREN

By MARY BLYTHE WILSON, R.N., Superintendent, Rainbow Hospital for Crippled and Convalescent Children, South Euclid, Ohio.

IT HAS been thirty-one years since the Rainbow Hospital work first was started by a group of young Cleveland girls, banded together with the Maltese Cross of the King's Daughters as their emblem, to care for needy, convalescent, undernourished children. The work has grown in many directions, but with all the changes incidental to its expansion, two fundamentals have not been lost sight of. It has always been a work for convalescent children, and the problems of the child have not been subordinated to the exigencies of combined adult care. Acute conditions have been left to the hospitals organized to meet their needs, and care has been exercised to prevent incurable cases from blocking the admission and treatment of children who could receive a permanent benefit. And throughout its history the work and its benefits have been absolutely nonsectarian and without regard to races and creeds.

The old "cottage" where Rainbow Hospital began its work with convalescent children and a corner of the new concrete building which accommodates seventy-five patients.

For several years, the work consisted chiefly of finding children who needed country air and general building-up, and providing them with two weeks' care, out-of-town, during the summer months. Then a little summer home was rented and opened on the lake shore and, of course, children soon were found who needed more than two weeks' treatment; these were kept all summer and frequently returned the following year. Later the Rainbow Circle combined with the Kinderheim, a similar work, and the Rainbow Cottage was founded in 1890 and incorporated in 1896.

Records of that date tell of the same methods and objectives as those which animate the work at the present—pure air, suitable food, healthful surroundings, under the advice of a visiting and consulting staff of physicians, resulting in rosy, happy, good children, which means well children.

Two Weeks' Camp is Extended

In 1898 through the generous gift of one of the "board of lady managers" and her husband, a permanent home was bought and provided for Rainbow Cottage. About that time the Children's Fresh Air Camp took over the task of giving the two summer weeks in the country, and Rainbow Cottage was kept filled with children needing lengthier treatment.

These children came from social settlements, day nurseries, hospitals, institutional homes, but chiefly from their own homes through recommendations from dispensaries and physicians.

One of the chief sources of funds at that time was from "supported beds." The appeal was made: "Can anyone invest fifty dollars to better advantage, than in giving a child (less fortunate than one dear to you) the benefit of good nursing, nutritious food and country air?"

Schools, kindergartens and societies for young people responded, as well as individual philanthropists, and in addition the corporation of devoted women administering the organization came forward with generous personal gifts and contributions in answer to every appeal for necessary improvement and emergency expense. An endowment fund was created and later a building fund.

Three physicians were visiting at that time and nine acting as consultants. There were twenty-five beds. Eighty-six children cared for during summer months in 3,255 treatment days; the per capita per diem cost was 66 cents. This was prior to 1900.

In 1906, for the first time it was found possible to keep the cottage open from June until December and since that time it has never been closed.

Affiliates with Lakeside Hospital

One of the next steps, along with the gradual growth of the work and greater variety of diseases treated, was an affiliation worked out with Lakeside Hospital in Cleveland, the Western Reserve University teaching hospital, which affected the medical staff and social service.

By this arrangement Rainbow Cottage continued to have its board of trustees, hospital administration and financial affairs absolutely independent of Lakeside, but all patients were admitted through the wards and out-patient department of that hospital and its medical staff was responsible for treating children transferred from the hospital to Rainbow Cottage. There was also an arrangement whereby a senior student from Western Reserve medical school resided at Rainbow and gave his leisure time to medical work there.

A sunny ward at Rainbow Hospital

Orthopedic patients get the advantage of sun and outdoor air

The social service follow-up work of the Rainbow nurse, first started in 1905, was intimately affected by the Lakeside affiliation. All children leaving Rainbow were referred back to the Lakeside out-patient department but were still considered Rainbow patients and were followed by the Rainbow social worker, acting under direction of physicians in charge of the Lakeside out-patient department. All medical records were kept at Lakeside and social records were kept at the Rainbow office. This entire plan of affiliation was severed later to broaden the work.

Some Rainbow patients at their basketry.

At present, all hospitals and dispensaries in Cleveland and any reputable physician may refer needy crippled and convalescent children to Rainbow Hospital and they are admitted subject to approval of the resident physician and treated by the Rainbow staff, a closed staff, appointed by the board of trustees of Rainbow Hospital on recommendation from the existing staff. Patients when discharged go back for medical treatment to the source from which they entered, the Rainbow social service taking no cognizance of case after the return to the proper dispensary is assured.

There is an Orthopedic Council in Cleveland, consisting of reputable orthopedic physicians in practice in the city. The Rainbow Hospital staff has a representative appointed, on recommendation of this Council, from each hospital and dispensary handling orthopedic work. All orthopedic cases have continuous treatment by the same physician, or assistant, from the time they enter the out-patient department, go to hospital for treatment of acute conditions, to Convalescent Hospital and back to out-patient department again. They also have the same social service.

In 1913, the name of the corporation was changed legally from the Rainbow Cottage to the Rainbow Hospital for Crippled and Convalescent Children. A new fireproof hospital building of fifty beds was erected and in 1920 the capacity was increased to seventy-five beds with an additional summer unit to bring it up to 100. Hospital beds were 92 per cent occupied during the year. Three hundred and twenty-five patients were treated in a year. Upwards of 59,000 hospital days are recorded and the per capita diem cost was $2.25.

During the last Community Chest drive in Cleveland, this window attracted much attention. It shows dolls in braces, frames and other orthopedic appliances, and also a display of the children's handwork.

Present Hospital Has 75 Beds

Today Rainbow has fifty beds for orthopedic cases and twenty-five for convalescent medical cases. It is situated at South Euclid, four miles from the city limits of Cleveland, Ohio, on a high plateau, where owing to the steep grade it is said the atmosphere will never be polluted by the near approach of railroads and factories. There are thirteen acres attached, including lawns, flower gardens, woodland, vineyard and orchards. The property was beautifully landscaped and planted by a generous benefactor.

During the months May to October inclusive, the summer ward caring for ambulatory cases only is run. The proportion of bed patients to ambulatory is 60 per cent. The age limit is from two years to twelve, though exceptions are made in case of older girls. A unit for baby work is a crying and immediate need, as it is impossible to refuse the cases of tuberculous spines and hips among children under two years.

Owing to the abundant facilities for administering fresh air, sunshine, and a generous diet, certain cases needing a protracted treatment do very well and show none of the signs of long institutional confinement, but are strikingly ruddy of cheek, high spirited and make considerable gain in weight.

There has been an increase in the number of bone and joint diseases treated, in proportion to other conditions. This type of case averages over 50 per cent of the hospital population and shows marked benefit from local sunning, rest and nutrition.

The poliomyelitis and rickets cases, under a regime of massage and muscle training and general hygienic measures, are also an interesting part of the work. Marked results from treatment here have been shown in convalescent medical cases of following type: valvular cardiac conditions past acute stage, chorea, malnutrition, unresolved pneumonia, pleurisies, bronchitis, nephritis, empyema, glandular infections and phlyctenular conjunctivitis.

The number of individual children treated on the medical service usually exceeds the number of orthopedic cases, though the bed capacity for medical cases is one-third. Also the good results on medical service are more tangible.

No time limit for treatment is put on any case. It is treated according to its needs as discovered by physician and social service department. Some of the orthopedic cases have remained six years or more, and most of the hip and spine cases remain at least a year. An excellent x-ray equipment and a large solarium contribute greatly to good results in these cases.

To meet the need of long drawn out cases, an effective school organization has been worked up. Teachers are paid by the Rainbow Corporation, though had the institution been within the city limits, it might have been possible to secure aid for this work from the Cleveland board of education. However, a close cooperation with city schools is kept up by an exchange of transfer and

Interested spectators at the shop window, viewing the Rainbow Hospital doll exhibit and children's handwork.

grade cards. It has been found that many a child has skipped a grade during his sojourn at Rainbow.

The occupational work is largely featured in the school and has attained considerable distinction. Sales of work are held each year, the proceeds going to defray cost of materials, and the remainder to the pupils making the articles sold. Some have earned between $30 and $40 during their year. There have been several exhibitions of pupils' work in the annual showing of the work of Cleveland Artists and Craftsmen at the Art Museum; and honorable mention and first prizes have been earned for loom weaving.

Both bed and ambulatory cases are taught in the school and no child of school age, unless forbidden by physician, has less than two hours daily of either classroom or bedside instruction.

In all these changing years, the affairs of Rainbow have been managed by a corporation of women, now increased to 100 members, who are represented by a board of trustees, each member of which is an active participant in running the hospital. No emergency but is adequately met, from producing city watering carts full of water to empty into the tank when the wells went dry, to producing ten kiddie cars when an extra demand was made to meet the needs of the congenital hip cases.

These women have asked advice from the best business minds in Cleveland in managing affairs and of the best physicians in settling medical questions, but the management has rested in their hands and has been passed on to a second generation, trained to knowledge of and devotion to the interests of Rainbow. The tradition is handed down and Rainbow has earned an enviable place in the hearts of a community, noted for its good feeling towards the less fortunate neighbors.

WHAT THE DOCTORS GIVE*

Few realize what a large contribution is made to the hospitals by their medical and surgical staffs. It is only from private patients that the doctors are allowed to accept a fee. The private patients in the United Hospitals of New York are only 24 per cent of the total. This means that the doctors and surgeons treat 76 out of every 100 patients without a charge for their services.

Have they not a right, therefore, to ask that the public will at least provide the material equipment, the laboratories and scientific instruments, the food, medical supplies and labor necessary to carry on the hospitals to which the doctors contribute their brains, trained skill and valuable time? The services of interns and of nurses whose compensation is largely in their training, also amount to a substantial gift to the hospitals, worthy of public appreciation.

During the past ten years the average stay of patients in the United Hospitals has dropped from 20.7 days in 1911 to 15.4 days in 1921. This is equivalent to adding 25 per cent of the capacity of the hospitals, or a saving of one-quarter in the cost of each case treated. The drop which has been very steady, amounting to about half a day *each* year, is due to several causes:

1. Improved facilities for diagnosis and treatment.
2. More staff consultations, by which the nature of the case is early determined and time saved in applying the remedy.
3. Larger provision for convalescent care, making earlier discharge possible without danger to the patient.
4. Improvement of and closer cooperation with the dispensaries making it possible for them to continue the treatment of patients as ambulatory cases, who otherwise would continue to occupy a bed.
5. The development of the social service department, which often contributes information of great value to the doctor in understanding the trouble, and which helps the patient by removing fear and misunderstanding and by relieving anxiety as to family matters.

*From the annual report of the United Hospital Fund of New York prepared by Frederick D. Greene, general secretary.

The Doctors Contribution of Free Service to the United Hospitals – 1921

Private Patients 46,658 – 24%	Ward Paying Patients 87,713 – 45%	City Cases 21,679 11%	Free Patients 39,229 – 20%

Paying Fees-24% Patients Paying No Fees – 76%

SOME COMMON MISTAKES IN PLANNING DISPENSARIES

By MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary, Committee on Dispensary Development, New York, N. Y.

ALADDIN'S genii built him a palace over night. One wonders whether he and his bride found it convenient to live in, and whether they ever wished their magic servants had taken a little more time so as to be sure of arranging most appropriately the practical conveniences of the establishment. Perhaps, however, genii can do better than those more earthly creatures who generally plan dispensaries. Certainly not a few dispensaries that one visits seem not even to have been planned over night, but merely set up.

The first and most common mistake in planning dispensaries appears to be that the architects, building committees, and hospital officials concerned draw plans without thinking out the specific purposes which the dispensary is to fulfill.

Too Little Thought Given Dispensary

Dispensaries are often a recent addition to the hospital family, not yet admitted to dine at the main table. Many hospitals start an out-patient department by assigning a few existing rooms in the basement. Later, when the work grows so that more space becomes imperative, some reconstructions are made, often also in the basement; or, if an entirely new hospital building or extensive additions are under way, a new pavilion is built, or a portion of a new pavilion is assigned, as a new out-patient department.

In THE MODERN HOSPITAL'S competition for a small community hospital building, the specifications regarding the out-patient department almost all are included within two phrases, "waiting room" and "treatment room for out-patients." Items regarding the service to bed patients are carefully detailed. The out-patient department is recognized only as having the tip of its little finger touching the pie.

The second common mistake in planning out-patient departments is failure to realize that ambulatory patients are either important medically or present any particular problems of management requiring careful planning of the space in which they are to be received and treated. As a matter of fact, space to be used for ambulatory patients needs to be planned very carefully if economy of construction and operation is to be combined with maximum service to the sick. The patient is put into bed and stays put. Patients who are up and about and who come in throngs at certain times present a problem with a larger number of varying factors. The space for their reception, registration, admission, waiting, examination, and treatment must be very carefully thought out if crowding, confusion, waste of time and deterioration of service are to be avoided.

The problem of the out-patient department of a general hospital which is to have separate clinics in medicine, surgery, and eight or ten specialties, is quite different from that of an out-patient department almost entirely surgical in a community where the great bulk of patients will be in industrial surgery, and the other clinics, though important, will be subsidiary. The planning of the latter is again different from that of the dispensary which is to treat children; and so on.

Perhaps the most common error in existing dispensaries, for which those who plan them are responsible, is failure to provide sufficient administrative space. Not infrequently, the area assigned to individual departments, medical, surgical, orthopedic, etc., will be found reasonably sufficient, whereas the space near the front door for the admission and reception of patients, for waiting room, and for the care and distribution of records will be entirely inadequate. A hospital in New England which planned a new out-patient department a few years ago, was found—just before it was too late—to have drawn plans for an out-patient department expected to receive 150 patients during a working session, in which the space allowed for admission was a mere vestibule near the entrance, about fifteen by twelve feet, with the corridors near the clinics so narrow as to compel crowding if a row of benches were placed for waiting. The room for interviewing patients at admission was a narrow space behind a rail, and the place for records was practically nil.

As a rule, the failure to allow sufficient space for administrative purposes in the out-patient department is due to the lack of attention paid it by the administrative authority of the hospital. The superintendent is often wholly immersed in hospital housekeeping and is unfamiliar with the problems of an out-patient department. In planning a new hospital, he would be keen to see that ninety per cent of the hospital cubage was not given to wards and operating rooms, with only ten per cent for kitchens, service rooms, and necessary living quarters; but of the administrative aspects of the out-patient department, he has either not thought or he is not consulted.

The physicians interested in their several departments of service generally lay their plans for their several bailiwicks before the architect or the building committee. I have in mind a large well-known institution which, some years ago, built an addition to its out-patient department to provide for a large increase in the number of patients. This required a three-story and basement addition which was to house four clinics, and added about forty per cent to the capacity of the entire dispensary. No consideration was given to the fact that this forty per cent addition would require extra administrative space for admission, waiting, and records, nor that additional toilet and other conveniences would be required. The pavilion was built with some excellent detailed planning for the particular medical and surgical clinics to be included in it; but no consideration being given to administrative points, the institution found itself much overcrowded in its main admission hall, and unprovided with sufficient toilet facilities for the hundreds of patients which it received daily. A well-known children's hospital built a new out-patient department without any covered area in which baby-carriages could be parked, though ground was not lacking.

Proportionate Space to Various Departments

Planning by departments and letting the most influential and popular doctors get the best or the most space, instead of planning as a whole with allowance for the needs of both medical and administrative sides, is an all too characteristic mistake in present dispensary planning. Disproportionate space to various departments is an outgrowth of the same condition. Thus, in a dispensary building recently described in THE MODERN HOSPITAL, the department of tuberculosis is given an amount of space which would apparently mean that it is expected to receive and care for two or three times as many patients as the department of general medicine. This may have been the intention and may correspond to the expected local demand.

Those interested in tuberculosis clinics are well organized, and have thought out and more or less standardized their needs and demands. This is a great advantage and no criticism is suggested of the claims of tuberculosis for adequate space and arrangement. It is other departments of the dispensary that may suffer if a due proportion between the needs of different branches is not maintained by a thoughtful and impartial authority responsible for the planning of the institution as a whole.

In planning examining rooms the general fault is to make them too large. This may be a survival of the days when a crowd of patients was hurried into a room, the doctor seeing one after another, or the days in which the teaching of medical students was done in large groups, so that ten to twenty students were gathered together around a single patient. Nowadays good medical teaching is done with individual students or in very small sections, and the student examines patients individually. Didactic teaching and demonstration are relegated to the amphitheaters and lecture rooms.

May Save Space in Examining Rooms

The large examining or treating room is also a survival of the day when privacy was not thought necessary to the patient's dignity or to medical efficiency. An examining room in a department of medicine or pediatrics need not be more than six by eight feet, although six by nine, or seven by nine, is sometimes more convenient. A series of small rooms or booths provided with the necessary examining table, chair and stool, with carefully planned lighting, may open on a single history corridor, or under some circumstances, upon the main corridor, and very much larger use be made of a given area than if rooms ten by twelve, or eleven by fourteen are designed. The idea is gradually permeating the minds of those who plan dispensaries that much time can be saved by doctors, much saved in administration, and a great gain in efficiency be brought about if the clinic rooms of a given department (e. g., medicine, surgery, ear, nose and throat), are so planned as to bring the patients in from the waiting room through a single entrance and out again through the same entrance, so that a complete control can be kept of intake and outgo; so that patients can be distributed by a secretary or "clinic executive" to the physicians in order, on time, with their records, and the doctor be assisted by being relieved of administrative functions.

The floor plans of a large new out-patient department recently examined showed an arrangement in the department of general medicine with two separate entrances from a history corridor to two waiting rooms. Had the doctors, with this arrangement of rooms, been provided with clerical or administrative help, two paid persons would have had to have been furnished instead of one.

Attention to detail in the planning of lighting, the placing of equipment, etc., is greatly needed, and special consideration is required for each department. The demands of laryngology, ophthalmology, surgery, orthopedics, general medicine, pediatrics and other departments, all vary with the medical nature of the work and the general

size of the clinic expected. Proper attention to these details promotes the comfort of the patients and convenience, efficiency and economy for the medical and administrative staff. These details can be planned by an architect only with the advice of some one who knows the exact purposes for which the rooms are to be used, and the way the particular kind of clinic will usually work. That means the combination of some one who is familiar with the medical character of the clinic (e.g., the doctor in charge), with some one who has the administrative and economic aspects in mind. Sometimes a clinic physician combines both points of view, but this is rare. The obligation is clearly upon the superintendent to think about this problem. Too little thinking of this kind has been done in the past. Where a start has not been already made, it is time to begin.

The best way to avoid the above mistakes and others which might be mentioned is to start planning a dispensary after careful study of specific purposes and functions, and to base the planning upon certain sound principles of organization and management of medical service for ambulatory cases. A suggestion of some of these principles will be attempted in a succeeding paper.

NEW TARIFF PROVISIONS ON DRUGS AND HOSPITAL SUPPLIES

Since the tariff bill has become a law, a summary of some of the items which will affect hospitals is in order. The bi-weekly statement of the National Health Council contains an abstract of some of the more important provisions.

The Dutiable List

In the haste to bring the bill to final passage, a compromise was effected on the dye and synthetic medicine schedules by fixing a rate of 55 per cent on intermediates and 60 per cent on finished products. These rates are, after two years, to be reduced to 40 per cent and 45 per cent respectively. The rates are based on American valuation and are in addition to a duty of seven cents a pound in each instance. Senate rates on acids generally prevailed in the final passage of the bill. On alcohols the House rates generally prevail. They include menthanol or wood alcohol at 12 cents per gallon; ethyl for non-beverage purposes at 15 cents a gallon. Other rates include:

Antimony oxide, 2 cents per pound; tartar emetic, six cents per pound; Rochelle salts, 5 cents a pound; Balsams, copaiba, fir or Canada Peru, tolu and all other balsams, ten per cent advalorem.

Barium carbonate, 1 cent a pound; barium chloride, 1¼ cents per pound; barium dioxide, 4 cents a pound.

Chlorinated lime, 3/10 of 1 cent a pound.

Caffeine, $1.50 per pound. Calomel, corrosive sublimate and other mecurial preparations, 45 per cent advoloreum. (This is an advance of 30 per cent over the previous existing law.) Carbon tetrachloride, 2½ cents a pound; chloroform, 6 cents a pound. (The present rate is 2 cents per pound). Casein or lactarene, 2½ cents per pound. (Casein was free of duty under the Payne-Aldrich and also Underwood tariff laws.) Chemical compounds, salts and mixtures of bismuth 35 per cent. (It was free of duty in the Underwood law).

An important schedule which fixes the rates on chemicals, drugs, medicinal and similar substances, when imported in capsules, pills or similar forms bear the duty of 25 per cent which is exactly the same rate as in the the Payne-Aldrich and Underwood laws.

No change is made in the duty on drugs made from barks, beans, berries, herbs, roots, etc. Belladona and digitalis are changed from 10 per cent to 25 per cent advalorem. Ergot is unchanged at 10 per cent advalorem.

Senate rates on gelatin were reduced as follows: Edible gelatin valued at less than 40 cents a pound, 20 per cent and 3½ cents a pound; valued at 40 cents or more a pound, 20 per cent and 7 cents a pound. Glycerine, refined, stays at 2 cents per pound (the Underwood rate), Formalin, 2 cents a pound. The rate on crude iodine is free as in the Underwood law; but the duty on resublimed iodine is 20 per cent, whereas it was free in the Underwood law. Bromine and bromine compounds have a duty of ten cents per pound, (free under the Underwood law.) Extracts of licorice are 25 per cent advalorem. (They are one cent per pound in the Underwood law.) Citrate of lime is 7 cents per pound. Epsom salts one-half cent per pound; (It was one-tenth of cent per pound in Underwood law). The duty on Menthol is 50 cents per pound which is the same as the Underwood law. No change is made in the duty of one cent per pound on crude or natural camphor; the rate is advanced from 5 to 6 cents per pound on refined or synthetic camphor.

On castor oil the House rate of 3 cents per pound prevail. (This is an increase over the Underwood law which was 12 cents per gallon.) The rates on opium are unchanged from the Underwood law, but cocaine, ecgonine and derivatives thereof are advanced from $2 to $2.60 per ounce. Strychnine and salts 15 cents per ounce. (It was free in the Underwood law.)

Plasters, healing and curative, 20 per cent ad valorem.

On scientific instruments the schedules follow:

Biological, chemical, pharmaceutical and surgical instruments, 65 per cent ad valorem. Lenses, 40 per cent ad valorem. Optical glass and equipment, 45 per cent ad valorem. Microscopes, 45 per cent ad valorem. Philosophical and scientific instruments composed of metal, 40 per cent ad valorem.

The Free List

Among the articles on the free list are:

Antitoxins, vaccines, viruses, serums and bacterins.

Barks, cinchona or other, from which quinine may be extracted.

Borax.

Capper sulphate.

Cyanide, potassium cyanide, sodium cyanide and all cyanide salts.

Drugs, natural and uncompounded.

Leeches.

Nux vomica.

Phosphates crude and apatite.

Potassium chloride and nitrate.

Quinine sulphate and all alkaloids and salts of alkaloids of cinchona.

Radium and salts of and radioactive substitutes.

Skeletons and other preparations of anatomy.

Teeth, natural.

Drugs, medicines, or articles to prevent conception are prohibited from importation, along with immoral objects.

EVANS HOSPITAL, A COMMUNITY INSTITUTION IN EASTERN NEBRASKA

By JOHN HELLEBERG, of Grabe & Helleberg, Architects, Columbus, Nebr.

THREE years ago Dr. C. D. Evans Sr. and a few progressive citizens of the town got together and decided that a new and up-to-date hospital, non-sectarian and open to all, would be a good thing for Columbus, Nebraska.

The hospital is located on a full city block in the west part of the residence section, away from all noise and traffic, but still close enough for convenience. The building is of a classic design and is fireproof, being constructed of reinforced concrete. All the exterior walls, except the fourth story, are faced with "oak bark" face brick with "flush cut" cream colored motor joints; the cornice and trim is of cream colored semi-glazed terra cotta. The fourth story walls are finished with white stucco and have a wide projecting wood cornice. All the exterior window and door frames are painted a tobacco brown.

Shaped Like an Aeroplane

The plan of the building resembles an aeroplane, the wings representing the main building; the nose, the main entrance, waiting room and office; the fuselage, the connecting corridor to the isolation wards; and the tail, the isolation wards and power house.

A basement extending under the central part of the main building, drive, garage and isolation wards furnishes space for the boiler room, coal bin, ash pit, clothes chute, refrigerating room, elevator machinery and storerooms.

The first floor of the main building has a waiting room next to the main entrance, and separated from this by a hall is the office. The hall connects to the main corridor, and here the following rooms are located: an emergency dressing room, emergency ward, dining room, kitchen, x-ray room and dark room, laboratory, superintendent's private rooms, drug room, toilets and bathrooms. In the center of the corridor the stairways are located. These are made of steel with composition filled treads, cast iron newels, square steel balusters and wood handrail. On the right hand side of the stairs is the elevator. This is an electric "push button" type and operates between the basement and the fourth floors. A dumbwaiter is located on the left side of the stairs opening into the kitchen, and this plies on each floor.

On the second floor are beautifully furnished private rooms, two of these with private bath and toilet, a ward, and a spacious sun room with large casement windows on three sides. The operating department is on this floor and consists of two operating rooms, having large steel sash glazed

Plans of the basement (left) and first floor of Evans Hospital, Columbus, Nebr.

WITHIN AND WITHOUT THE EVANS COMMUNITY HOSPITAL PLANT

with plate glass and additional skylights; a sterilizing room equipped with the latest and most approved sterilizers; a scrub room with three surgeons' sinks; a large anesthetizing room; two doctors' dressing rooms with showers of pink Tennessee marble; and a supply closet.

Contagious Wards Reached by Passage

Two separate wards for contagious diseases are reached from this floor through an enclosed passageway.

On the third floor are private rooms, two with private bath and toilet, and a ward. These rooms are finished and furnished the same as the rooms on the second floor.

The fourth floor is occupied entirely by the maternity department, which consists of a delivery room, a nursery having dumbwaiter service from the kitchen, recovery rooms with toilet and closet and a nurse's room.

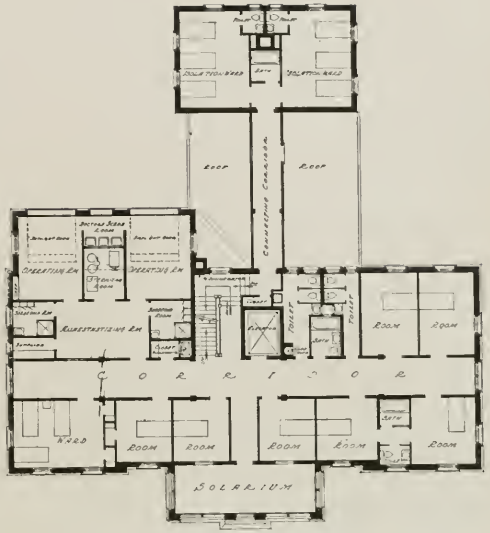
On the first, second and third floor toilets for both sexes are provided. All toilet stalls are made of Napoleon gray marble with nickel plated trimmings. Bathrooms are located on each floor between these toilets.

The details of the interior finish in every part of the hospital have been carefully studied. All the plastering is Keene's cement and all corners are rounded. The floors and base are of cement, the base being made with a sanitary cove where it joins the floor; everything has been done to make the building as easy to clean and as nearly aseptic as possible. The doors throughout are of the flat slab type and these, as well as the other interior wood work, are cream enameled, except in the operating department where everything is white.

Two boilers are located in the boiler room, one a low pressure cast iron steam boiler for the heating of the building, the other a forty pound pressure steel boiler, which heats all the water used and furnishes steam for the kitchen equipment and the sterilizers. The heating system is a two-pipe vacuum system. This in my opinion is much to be preferred to a gravity system of steam heating, as all condensation is pumped back into the boiler eliminating the possibility of the radiators filling with water where the windows are kept open in cold weather. It also does away with air valves necessary on a gravity system, which so often cause annoyance through leakage and escaping steam if not properly regulated.

A water softening plant is located in the basement. This softens all the hot water used. There is also in the basement an incinerator for eliminating rubbish and waste paper, which has receiving doors, one on each floor.

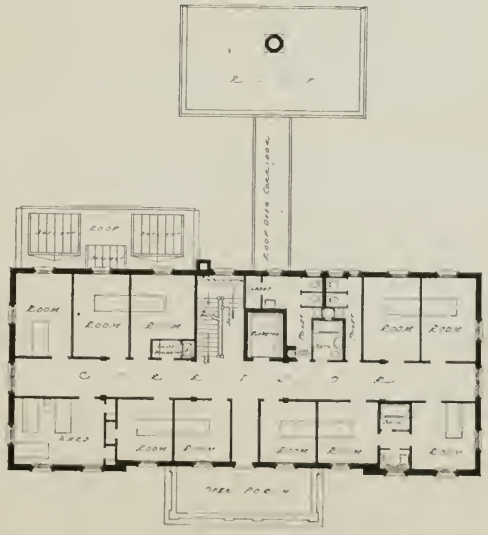
An intercommunicating telephone system is in-



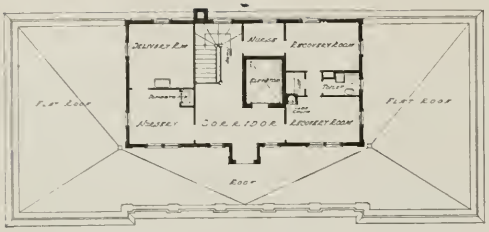
Second floor plan, Evans Hospital

stalled with connection to the city telephone; the switchboard is in the general office and stations are in the superintendent's private rooms, the nurses' desk on each floor, x-ray room, kitchen, boiler room, emergency dressing room, operating department and in most of the patients' rooms.

The silent call system is arranged so that when a signal is given, a lamp is lighted over the door of the room from which the call comes and also in



Third floor plan, Evans Hospital



Fourth floor and roof plan, Evans Hospital

the head nurse's office and the nurse's desk on each floor; these lights keep on burning until the nurse reaches the patient and extinguishes them by pushing a botton in the switch plate in the room. Each switch plate of the silent call system in the patients' rooms is provided with a plug for the attachment of reading lamps.

The kitchen equipment consists of two gas ranges, a vegetable steamer, combination steam table, cook's table and dishwarmer, urn stand and cupwarmer, coffee and hot water urns, serving table with cupboard for dish storage below, milk and cream cabinet, baker's table, vegetable sink, pot sink and butcher's sink. A large canopy extends over the ranges, connected to the incinerator smokestack, which draws all the smoke and steam out of the kitchen.

Adjoining the kitchen is a storage and canned goods room where the supplies for immediate use are kept. A large refrigerator is located in the kitchen and a refrigerating plant and three large coolers are in a room in the basement.

Plant Costs $235,000

A seven-room stucco bungalow for nurses' home is near the hospital. This is heated from the hospital and has accommodations for ten nurses.

The building was designed by Grabe & Helleberg of Columbus, the work being executed under their directions. The building cost approximately $160,000; the equipment, $50,000; the stucco bungalow for resident nurses, $5,000; and the grounds, $20,000.

Dr. C. D. Evans Sr. is the president of the hospital association and chief of staff. Miss Christine M. Hendrie, R.N. is general superintendent.

TRANSFER MADE OF $4,000,000 SITE FOR MEDICAL CENTER

The Joint Administrative Board of Columbia University and the Presbyterian Hospital has announced that the site for the new Medical Center has been transferred to Columbia University and the Presbyterian Hospital. The land transferred extends between 165th Street and 168th Street from Broadway to the Hudson River. This land, which is somewhat in excess of twenty acres and valued at about $4,000,000, is given by Mrs. Stephen V. Harkness and Edward S. Harkness. The necessary agreements between Columbia University and the Presbyterian Hospital have been completed whereby this land is divided between the two institutions and is held by them for the development of the new Medical Center.

Further announcement is made of completion of agreement between Presbyterian Hospital, Columbia University, and Mrs. Stephen V. Harkness as the donor, for the transfer of a fund of $1,300,000 to Columbia University for the endowment of educational and scientific work in the school of medicine and the Presbyterian Hospital.

Additional gifts by Edward S. Harkness are announced of $1,000,000 toward the construction of the new Presbyterian Hospital, and a gift of $1,000,000 to Columbia University for the endowment of educational and scientific work in the school of medicine.

At the request of the trustees of Columbia University the Joint Administrative Board is supplementing its work of preparing plans for the College of Physicians and Surgeons and the Presbyterian Hospital by preparing preliminary plans for a new Vanderbilt Clinic and a new Sloane Hospital for Women, which it is hoped will be erected on the same site and become a part of the new Medical Center.

LAY CORNERSTONE OF NEW BETH ISRAEL HOSPITAL, NEW YORK

On November 5, at 2.30 o'clock, the cornerstone of the new Beth Israel Hospital was laid by Mr. I. L. Phillips, chairman of the building committee. The new building will house 510 patients, with individual rooms and indivdiual service, and will cost over $3,000,000.

Addresses were made by the following: Herbert C. Hoover, secretary of commerce; Nathan L. Miller, governor of New York; John F. Hylan, mayor of the city of New York; Bird S. Coler, commissioner of public welfare; Arthur Lehman, president of Federation of Jewish Philanthropic Societies; Felix M. Warburg, chairman of the board; Col. H. A. Guinzburg, chairman, United Building Fund; Louis Marshall; Adolph Lewisohn; Otto A. Rosalsky; and Joseph H. Cohen, president of the hospital. The ceremonies were largely attended and the newspapers commented editorially on the event.

Governor Miller, in his address, considered the hospital as a monument to the achievements of the immigrants to America and as an index to what the immigrants give to American civilization.

The Hearst newspapers throughout the United States made the following editorial comment on this occasion, calling it "An 'American' Event":

In 1890 a flood of Jewish refugees from Russia tested severely the proverbial passion of Jews to look after their own. At that time Beth Israel Hospital was founded as a small clinic to look after the sick poor among these victims of Russian autocracy.

Having looked on that sad picture, now look upon this, in contrast. Yesterday afternoon the new Beth Israel Hospital—"the tallest in the world," as everything in New York should be—witnessed the formal cornerstone laying of what is to be a $3,000,000 structure.

Among the officers and members are men who were themselves helped by the original clinic. In thirty years some of these men or their sons have become millionaires. It is such a consideration that makes this incident a distinctively American event. Where in the world but in our country could we witness such happy inspiring contrasts?

America is still the synonym of opportunity—not only for getting and gaining success and prosperity, but for giving and serving, and each on the large scale typical and possible in this generously human land.

THE PLANNING OF THE SMALL HOSPITAL

By EDWARD F. STEVENS, of Stevens & Lee, Architects, Boston and Toronto.

THE problem of planning the hospital of from twenty to fifty beds in such a manner that it will function in an economical as well as an efficient manner requires quite the same study as the designing of a hospital of greater capacity, for with the present medical requirements for diagnostic as well as treatment facilities we have quite an array of rooms and area taken before we begin to treat a single patient or to provide room for him.

However small the hospital, we should have facilities for proper diagnoses, which means at least x-ray and laboratory, properly constructed rooms for surgical operating, for maternity delivery, for proper segregation of sexes and classes, for some small facilities providing for medical equipment, and above all, space and equipment for the preparation and serving of palatable food—all of these, and more, before we can think of space for the patients' rooms or wards.

The essential units should be so located that they will function properly with the space occupied by the patients; in other words, the location of working units should be sufficiently near for economic service and sufficiently remote to deaden unpleasant sounds.

Four Essentials in Planning

The nearer we approach the principle used in planning an economic factory or department store the greater our efficiency. In other words, we may consider our sick patient the raw material and our convalescent patient the finished product. Anything that will serve toward the bringing of the former to the condition of the latter helps to make the hospital efficient. To that end, there are four essential points:

(1) Good medical attention,
(2) Good nursing,
(3) Good food,
(4) Quiet, comfortable and pleasant surroundings.

Medical Attention.—The medical attention will be taken for granted, for no hospital would be considered without this prerequisite. We must, however, provide a proper workshop for these medical experts.

Good Nursing.—The nursing problem must be solved by the hospital and to secure educated, efficient young ladies as nurses, suitable and homelike housing is necessary, whether within or without the hospital building. If within, then seclusion and separation from the patients' portion should be established. It is always desirable, however, to provide separate housing for nurses whose work while on duty is most intense and whose leisure hours should be free from the environment of pain and suffering.

Good Food.—The problem of the preparation of good food is one which demands especial study. There should be ample, clean, well lighted storage for supplies and ample refrigerator space, located for economy of space and accessibility to the kitchen. The kitchen should be so planned as to avoid "cross currents" of service—that is, so that the raw food will enter at the working side of the kitchen, and in its process of manufacture to palatable food there will be no unnecessary motions or crossing and recrossing the kitchen area. The range, the steam cooker, the mechanical devices for mixing, chopping, freezing, etc., are all essential to prompt service.

The serving of the food after its preparation is even more important, and with the various devices for keeping food warm or cold there should be no reason for serving to the most remote patient in the hospital anything but palatable food.

The local serving kitchen or "servery" would seem to be essential, even with the heated serving wagons, for the occasional hot toast or drink must be quickly prepared and facilities should be had near at hand.

Quiet and Pleasant Surroundings.—In the manufacture of various commodities, some require heat, others cold; some moist and others dry atmosphere; some light and others darkness. It is quite the same with the patient in the hospital, and the well-planned hospital, be it large or small, makes provision for all of these conditions. All nature requires sunlight for proper development and so does the patient for normal recovery.

Temperature Needs to be Varied

A system of heating which provides a constant temperature of, say 68 degrees, is creating a condition contrary to nature. If the well person needs a variation of temperature for health, then the sick man needs it to become well. Good ventilation, preferably natural, which works all of the time, is better than the most scientific system which is out of order part of the time or too expensive to run all of the time. Windows of sufficient size to let in the light and sunshine should be near every patient and it should be possible to "flush" the room with sunshine some time in every twenty-four hours (when the sun is shining).

The quietness of the patients' rooms generally depends on the location of the ward in relation to surrounding noises and the location of the utility rooms in relation to the patients' rooms. While the sink room, the serving room, the toilets and baths must, of course, function for the comfort of the patient, they need not necessarily be centered directly opposite a patient's room.

Around a corner, a recessing of the entrance will oftentimes make the difference between a noisy and a quiet room. The elevator and stairs, always a source of noise, should be behind doors from the corridor.

To the end of quietness, construction and equipment constitute a great factor. The corridors, if built of fireproof material (and every hospital should be so built), will be more or less noisy. Much of this noise can be minimized or prevented by the use of proper hardware and floor covering. Perhaps one of the most noticeable noises is the clicking of the latch bolt on the door and the snapping of the door holders, both of which can be eliminated by the use of proper hardware. If the floors are of cork, rubber or linoleum, the noises from that source are minimized.

The demand for private, semi-private or intermediate rooms and the consequent increase of service and attendants makes it desirable to provide wards so constructed that the room will have the privacy of a single room combined with the efficiency and ease of service of a ward. Such a plan was described by the writer in the March issue of THE MODERN HOSPITAL.

Location of Operating Room

The "Medical Workshop."—At the recent conference at Atlantic City, the question was propounded, "Where should the operating room be located?" A voice from the back row whispered, "In the hospital!" It is the writer's belief that the operating unit should be placed where it will best function for the welfare of the hospital. A top light is no longer considered essential for the best lighting, so that the use of the top floor for operating is no longer considered necessary, if the first or any other floor will function to better advantage.

It will many times follow, that by constructing all of the so-called surgical and medical treatment rooms on the entrance floor, the efficiency of the hospital is increased; for with a limited floor space, the upper stories are left free to function entirely for patients' rooms and wards, with their necessary utilities.

The x-ray, the laboratory, and the medical treatment rooms can all be placed to advantage around the operating suite, and the noise and confusion which arises when they are placed on the floors with the patients can be avoided.

Lighting of the operating room, which should be on the north or as near north as possible, can be enhanced by carrying the glass line of the window slightly above the ceiling line of the room and thinning the floor construction at that point. If the operating room is on the upper floor, the window may be extended to greater vertical height.

Surrounding the operating room or rooms must be the utility rooms such as sterilizing, nurses' work and surgeons' locker rooms. The scrub-up may be in the open corridor, or, as some surgeons prefer, in the operating rooms. The laboratory of the small hospital may function with this section, although oftentimes it works out to better advantage on other floors. If an out-patient department is used, the laboratory and pharmacy should be placed in its immediate vicinity.

The administration department is mentioned last, not that it is less important but that its location is less important, as the hospital should be built up around the patient. Sufficient room should be given to this to ensure privacy for consultations, space for bookkeeping, and rooms for friends of patients. These offices are generally grouped around the entrance and made accessible to the public.

The entrance itself should be of sufficient importance and dignity to impress the visitor or patient with a homelike and welcoming atmosphere.

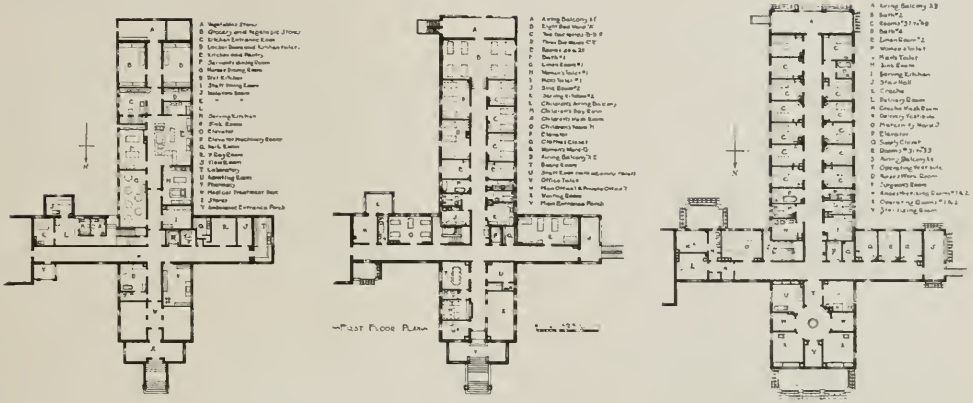
As illustrating some of the principles of hospital planning actually carried out by the writer, the plans of the following hospitals are submitted.

Airing Balconies a Feature

The Benjamin Stickney Cable Memorial Hospital,[1] in Ipswich, Mass., is erected in the center of a ten-acre lot. The ample space around the building, coupled with the natural beauty of the site, gives the architect more than usual opportunities for placing the rooms to the best advantage. The

[1] See The Modern Hospital, March, 1919, for plans.

A feature of the Barre City Hospital in Barre, Vt., is its extensive roof ward which may be seen in the photograph.



Ground, first and second floor plans of Good Samaritan Hospital at Sandusky, Ohio. There are no rooms in this hospital which face the north.

building faces the north, or toward the town proper, but practically all the rooms for patients are on the south, overlooking the beautiful valleys and hills in that direction.

The building, of fireproof materials, is designed in the early Georgian style so common in the old New England towns. It accommodates twenty patients on the first floor, and the second floor is also available for use of patients.

The ground floor contains the kitchen, dining rooms, x-ray, morgue, heating, and storage rooms; for the present, the second story is set apart for nurses and for a small isolation department.

To give assurance of security, a low brick wall is built around the patients' court, upon which three airing balconies open. These airing balconies, projecting to the east and west, cut off the cold winds from the north and east.

The plan is simple: one enters through the memorial entrance, which is finished in Colonial detail, passes up two steps to the main corridor and thence into the private patients' day room, or out into the patients' court.

On the east end of the building is located the men's ward, the operating department, and the ambulance entrance; on the west, the women's and maternity wards; on the northeast, the children's ward; on the south, four private rooms; and the north, the utilities.

No Large Wards Provided

The Barre City Hospital,[2] Barre, Vt., built on a sloping site in this "Granite City," functions as a medical center for that vicinity. The condition of the site allows the administration entrance to be placed one story below the ambulance entrance.

In planning this hospital no large wards were provided, as it was felt that a better segregation could be obtained with smaller wards, so that on the first floor were located four three-bed wards and seven single wards; also a small maternity department, entirely isolated, with delivery room, creche and creche wash-room.

The second floor is almost wholly devoted to private patients, consisting of one four-bed children's ward and nine private wards. A complete operating department is also provided on this floor and is composed of two operating rooms, anesthetizing room, nurses' work room, sterilizing room, and surgeons' locker rooms, all being shut off from the patients' quarters and planned for the most efficient service.

On each floor ample serving kitchens, sink rooms, bath and toilet rooms, linen storage closets, medicine closets, and nurses' stations are provided.

Large airing balconies at the south afford opportunities for patients to be wheeled into the open air, as all doors are wide enough for beds to pass through and all beds are provided with trucks, while the elevator connects all floors.

Perhaps the most interesting feature of the thirty-two bed hospital is the extensive roof ward, equipped with all the conveniences and accessories of indoor wards and commanding a wonderful view over the town and the adjoining hills.

The materials of construction are common brick, granite and terra-cotta, with floors of iron and concrete. The interior walls are of hollow tile, the floor finish of terrazzo, cement, and linoleum. The finish is simple, the windows wide, and the coloring of the inside is cheerful and attractive.

No North Rooms for Patients

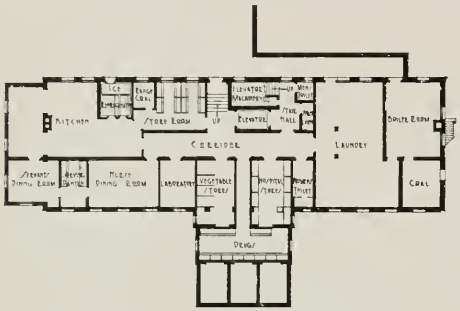
In the plans of the *Good Samaritan Hospital* at Sandusky, O., the problem is worked out a little

[2]See The Modern Hospital, November, 1915, for plans.

differently from any of the preceding examples. This building faces north, with the main axis, of course, north and south, and the cruciform shape makes possible the segregation of the different departments.

The east and west projections are but one room deep, leaving the corridor on the north side which gives ample light and air. With this arrangement, no rooms face directly to the north except the operating department and offices.

On the first story of the north projection are



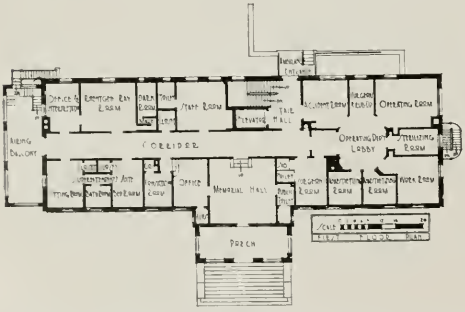
Plan of the ground floor, Soldiers and Sailors Memorial Hospital at Penn Yan, N. Y.

the offices, with a large waiting room on the right. These offices consist of the main business office and the superintendent's office on the left, with the board room directly in the rear. The remainder of the space in the north projection is taken up by the staff room.

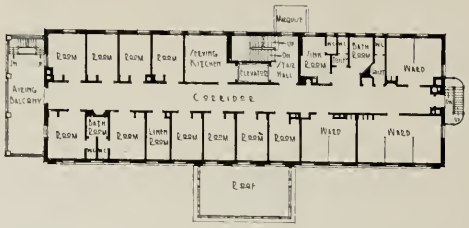
In the east projection is the children's ward, with its day room or play room, as well as the open airing balcony.

In the west projection is the women's five-bed ward.

The remainder of this floor is taken up by wards, both large and small. The largest ward in this plan is for eight beds, and the smallest for two. There are also on this floor two single-



The operating room is on the first floor in Soldiers and Sailors Memorial Hospital at Penn Yan, N. Y.



The largest ward in Memorial Hospital at Penn Yan, of which this is the second floor plan, is three beds. These are separated by a permanent screen.

bed or quiet rooms. The center portion is taken up with the utilities.

It will be noted that the entrance to the serving kitchen opens from a recessed portion of the corridor, with a view of reducing the amount of annoyance from this quarter of the building.

The staircase and elevator are in a fireproof enclosure.

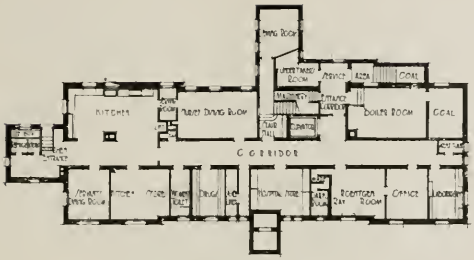
Operating Suite on Second Floor

On the second floor, directly above the offices, is the operating department, which consists of two major operating rooms, two anesthetizing rooms, a nurses' workroom, a sterilizing room and surgeon's room. The surgeons' scrub-up, it will be noticed, is placed in the center of the rotunda. In the east wing is located the maternity department, consisting of a delivery room, creche, creche washroom, and a three-bed maternity

Plan of third floor, Soldiers and Sailors Memorial Hospital at Penn Yan

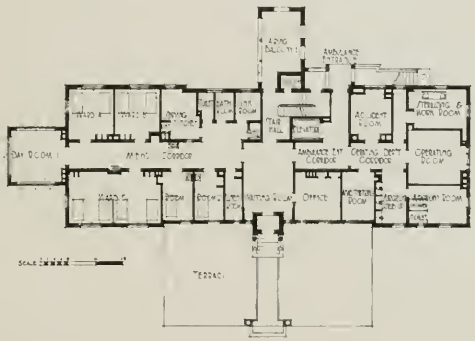
ward. This department is shut off from the rest of the hospital by two or three doors, in this way minimizing any disturbing noises which may come from this department. The remainder of this floor is divided into private rooms, both single and en suite.

On the ground floor, which is practically level with the ground, is located the isolation department (J, K, L, M, N on the plans), with direct exterior communication as well as a connection with the main corridor. The ambulance entrance at this level, together with the patients' admitting room, provides easy access to the elevator and to the upper stories. The remainder of this floor is taken up by the kitchen, the storeroom, servants' dining room, nurses' and staff's dining room, diet kitchen, x-ray department, laboratory and pharmacy.



Ground floor plan of Mary Lane Hospital, Ware, Mass.

In the plans of the *Soldiers and Sailors Memorial Hospital*, of Penn Yan, N. Y., the problem is taken up from another angle. In this hospital, one of the first things to be considered was the memorial feature, and a memorial hall of four hundred square feet area marks the entrance to the hospital. From this hall, one enters the main office; thence, ascending two steps, approaches the main corridor. It will be noted that no provision is made for patients on this floor, which is treated as a workshop for the institution.



Both patients' rooms and the operating suite are on the first floor at Mary Lane Hospital.

The operating department is approached from the ambulance entrance, through the accident room and from the main corridor. In this department are the major operating room, accident room, sterilizing room, nurses' work room, and two anesthetizing rooms. The surgeons' room is approached both from the operating corridor and from the main hospital corridor.

The remainder of this first or working floor is taken up by the stock room, and the roentgen-ray department which includes the operating room, the office, the interpretation room and the dark room. The suite of the superintendent of the hospital is on this floor. No other nurses are supposed to sleep in this hospital, as they are well and generously taken care of in the wooden building now on the site.

On the second floor are the general wards and private rooms. It is to be noted that the largest ward in this hospital is three beds and that these beds are separated from one another by a permanent screen. There is one suite of rooms, with bath and toilet connected.

The southern half of the third floor is used for maternity patients. In addition to the wards and private rooms, there are the delivery room, the creche, and the creche wash-room. It is to be noted here that both the delivery room and the creche are separated from the main corridor by two sets of doors—a very important thing for this department.

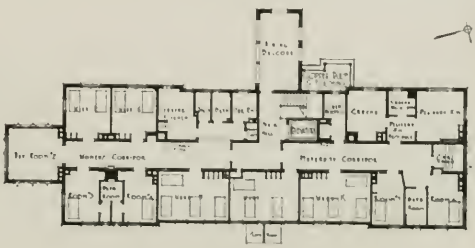
On both floors for patients, the sink rooms, bath rooms, and toilets are so placed as to give the least annoyance to the patients. The elevator and staircase are placed in the staircase enclosure, and there is no direct connection from the elevator except for the food trucks that go directly across the corridor.

On the ground floor are the kitchen, the servants' and nurses' dining rooms, laboratory, store room, laundry, and the boiler or heater room, making this a very complete small hospital.

In the *Mary Lane Hospital* at Ware, Mass., the problem is not like any of the foregoing. In other words, while the operating department is on the first floor, there are also certain patients on this floor. This is made possible on account of the contour of the land, as the lot drops off quite rapidly toward the west, making the basement much more available for rooms than is the case with any of the institutions previously mentioned.

The operating department is very similar to that of the last mentioned hospital. Here the sterilizing room has been combined with the workroom, making this a rather sizable room and so taking care of both departments.

In all of the plans it will be noted that provision for the surgeons' scrub-up is made either in the



Plan of second floor, Mary Lane Hospital

center of the rotunda or in a side corridor where there is no obstruction between the scrub-up sink and the door to the operating room.

The second story is made more or less flexible by the cutting off of the maternity department from the women's general corridor, and while it is similar to the Penn Yan hospital, the plan is worked out on somewhat different lines. Of course in a hospital of from twenty to forty beds the departments must be made more or less flexible, and so it is necessary to make more cut-offs in the corridor for the purpose of segregation or isolation of certain cases.

In all of the plans described, large airing balconies are provided, and these do or should face the south, or as near as possible to the south. To accomplish this in the Mary Lane Hospital, it was necessary to make a west projection, protecting the north side of this projection from the winds and opening the entire south side. This was so, also, in the plan of the Cable Memorial Hospital. It has been made possible to close some of these balconies from the elements by means of sliding or folding sashes, so as to make a veritable solarium if it is so desired.

Exterior of Lesser Importance

In these descriptions nothing has been said of the external architecture, as it is the writer's belief that a good plan will indicate to the designer the proper exterior treatment.

The question of available funds must necessarily be considered, but it should be borne in mind that the plan should always be worked out first and then adapted to a suitable elevation or exterior. So important is the plan that in the writer's own practice he is led to consider the plan as ninety points against ten for the exterior.

A PEACEFUL RETREAT FOR THE TUBERCULOUS SET IN THE SIERRA FOOTHILLS

By WILLIAM L. WHITTINGTON, M.D., Medical Director, Weimar Sanatorium, Weimar, Placer County, California.

WEIMAR Sanatorium, built and maintained by eleven northern California counties, during its two years of operation has gained a reputation as one of the state's chief hospitals for the treatment of the white plague.

A kindly nature molded the health-giving spot where the sanatorium stands. It is in Placer County, forty-eight miles northeast of Sacramento and four miles west of Colfax on the main line of the Southern Pacific railroad and of Lake Tahoe Highway at an elevation of 2,300 feet. There perched on a knoll and surrounded by stately pines and firs are grouped the buildings that comprise this modern health resort. The Lincoln highway from Sacramento to Truckee and Reno passes the front entrance to Weimar.

The view itself is an inspiration. To a sick man who has perhaps lived his life in the crowded city, it must be a revelation. In all directions there is an unobstructed, unbroken view; high snow-capped Sierras on one side and the low rolling foot-hills looking toward the valley on the other.

The sanatorium was formally opened for the reception of patients November 17, 1919. The buildings, arranged on the unit plan, consist of a central structure known as the administration and infirmary building surrounded by dormitories and other necessary structures that go to make up a modern sanatorium.

The administration building is 290 feet long. Here is located the office of the medical director and his assistants, a receiving suite, examination rooms, sterilizing room, operating room and x-ray room, laboratory, pharmacy, office and telephone exchange. In conjunction with this there is the chief nurse's office, the housekeeper's department,

The administration building at Weimar Sanatorium, Placer County, Cal., is blanketed by snow.

nurses' chart rooms, service rooms, diet kitchens, linen closets and numerous minor rooms of lesser importance.

The building faces the south; the west half is for women, and the east half for men, with a hallway running full length throughout the center of the building east and west and north and south. Broad porches extend the full length of the building in front, flooding the rooms with sunshine. At each end of the building is a twelve bed ward, glassed in. In the central portion of the building there are twenty-four private rooms, twelve for women and twelve for men. Throughout, the structure shows substantial workmanship wrought from the use of good material, the interior being in hard plaster and well finished woodwork.

Hope Cottage for Women at Weimar Sanatorium has a beautiful setting

A heating system provides warmth in winter for the central structure. The patients dormitories in the cottages are unheated; only a wood stove is installed in each building furnishing heat for the dressing, bath and locker rooms. Great care has been observed with a view of providing fresh air for patients, yet of avoiding all drafts where it is possible to eliminate them.

Equipment is Complete

North of the administration building and but a few hundred feet distant is located the power house, laundry, garage, and office quarters for the business superintendent. Two boilers of the latest type, fired with crude oil, furnish hot water for the buildings, steam for heating and for use in the laundry, although the machinery in the laundry is operated by electricity. In the latter may be found washing machines, dryers, water extractors and mangle; in fact, every device known to the up-to-date city laundry. In this work room the soiled linen accumulating from the entire hospital is carefully sorted, washed, ironed and returned to the linen room, ready for use again.

Directly in the rear of the laundry, quite a distance from the main group of sanatorium buildings, is the dormitory for male employes. To the rear of this building and down the hillside is an incinerator plant for burning sputum cups and paper napkins with which every patient is constantly provided. Also all accumulated garbage is burned daily. The sanitary features of a hospital of this character are most essential, and to this end the builders devoted much consideration. For instance, the sewage system is complete in every detail. The water system is thoroughly modern and all plumbing is of the type especially adapted to hospitals. All sewage and waste waters are directed into a septic tank.

A pumping station is located adjacent to an irrigation canal which has its source from Lake Spaulding on the south fork of the Yuba River supplies every department of the sanatorium with clear, pure mountain water.

Other buildings include eight cottages for male and female patients which house from twelve to eighteen patients each. All necessary day rooms, dressing rooms, locker rooms, bath rooms, shower rooms, lavatories and toilets for their convenience are provided in these cottages.

The nurses' home provides accommodation for thirty nurses and contains reception rooms, lecture and social hall, large sun porch which can be converted into a sleeping porch, dining room

and kitchen, baths, lavatories and showers, laundry and trunk rooms.

One of the chief buildings of the institution, the service building consisting of kitchen, dining room, ice plant and cold storage, was recently destroyed by fire. The loss was complete and there has been erected a new structure to replace it. This new building is of concrete and is fireproof throughout. The location is south of the administration building on the site of the former building.

Food Service on Cafeteria Plan

The food is wholesome and plentiful and, in addition to the regular menu, milk and eggs form a large portion of the diet. All patients who are able to go to their meals are served in the patients' dining rooms on the cafeteria plan. This style of serving has proved very popular and is a feasible and cleanly manner of serving meals on a large scale; at the same time it is a great saving of labor and energy. The culinary department is under the management of an experienced chef; the menu is outlined and approved by the medical director. The kitchen is modernly equipped with mechanical devices of various types to facilitate this work. There are steam cookers, food chopper, potato peeler, coffee grinder, and dish washing machine, operated by electricity. Two large steam tables keep the food hot during meal hours.

The sanatorium has four separate dining rooms, the largest for the male ambulant patients. A separate and smaller dining room for the female patients, one for officers and nurses and one for the other employes are provided. Separate service and separate dishes are furnished the officers, nurses and employes, but the same menu is served to all.

Very ill patients and those not able to walk to the dining room are served on trays at their bedside tables, and special diets selected from the regular menu and nourishments consisting of liquid, soft and light diets are furnished them. In addition to the regular diets, each sick person is allowed all the raw eggs and milk he desires. Usually these liquid nourishments come halfway between the regular meals. A dairy herd of tested Holstein cows supplies milk for the institution.

Any person suffering with tuberculosis who is a bona-fide resident of one of the eleven counties jointly interested in the Weimar Sanatorium, and unable to pay for treatment at a private hospital may enter the sanatorium providing he has lived in the state one year and has obtained an admission card through application and examination by his county physician, this card being countersigned by a member of the board of supervisors from the county in which he resides. There is no red tape connected with this procedure. It is a simple method and those requiring treatment need not be occasioned any delay. Transportation is furnished those unable to pay their fare. Those who are able to pay are admitted at a flat rate of $1.50 per day, the balance of the expenses being borne by the institution. These are known as pay patients, but receive the same care and attention as the county patients.

The cost of maintaining a patient at Weimar is $2.25 per day. In addition to this the state bureau of tuberculosis pays to the institution a subsidy of $3 per week on each county patient. No subsidy is received for pay patients.

Procedure Upon Arrival

Upon arriving at the sanatorium, the patient is at once taken before the medical director. Measurements, weight of the patient, visible symptoms and other information are tabulated on a card index which includes also a brief history of the patient. The patient is given a number. This facilitates the handling of all patients and obviates trouble in keeping a check on those who already have been treated at the sanatorium in case of future reference. When these preliminaries have been completed, the patient is sent to bed and regarded as a sick person until further observations are made. The following day the patient again appears before the doctor for an examination complete in every detail; all of the findings and data are entered upon the patient's medical history and chart and furnish the medical director with a minute history of the case.

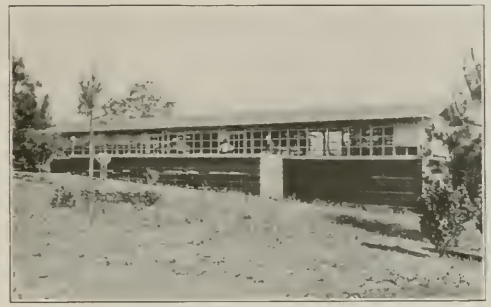
While under this early observation the laboratory tests are made, such as the sputum test for tuberculosis bacillus, hemoglobin test, urinalysis and Wassermann blood test. Fluoroscopy and the x-ray stereoscopic films of the lungs are taken. The tuberculin test is given children and the younger patients.

Weimar's equipment for aiding in diagnosis consists of one of the latest models of x-ray apparatus. After the period of observation consisting of about one week, the severity of the case is determined, and if incipient, the patient is assigned to a cottage. If the case is advanced, it is the custom to assign them as bed patients in the hospital proper.

The temperature of each patient in the institution is taken four times a day: 8. a. m., 12 m., 4 p. m. and 8 p. m., and recorded in a little clinical book compiled and published by the *Journal of Outdoor Life*. Patients are weighed weekly and the weights recorded on their medical chart. Each patient in the hospital is visited daily or oftener, if neces-

sary, by the medical director and individual medical attention given. All are required to observe rest hours from two to four p. m. daily, and to this there are no exceptions. Patients are not permitted to make their own beds or exercise when the temperature registers above 99.

At the time of admission each patient is given printed and verbal instructions. The rules are firm, but not drastic. Patients are not allowed to leave the institution grounds without permission from the medical director. After a patient's temperature has been normal for one week, he is allowed to go to the dining room for one meal. At the end of a few days he begins his second meal, and usually by the end of two weeks of normal temperature the patient is going to all of his meals. Afterwards he is permitted 30 minutes' exercise if it is found not to tax his strength.



"E" Cottage for Men at Weimar Sanatorium

The social side of life at Weimar is not neglected and everything is done to make the stay of the patient as comfortable and bright as possible. Frequent entertainments and moving picture shows relieve the monotony. Two chaplains, one Protestant and one Catholic, administer to the spiritual requirements of the patients, and give interesting talks on Sundays. Optimism is the watchword. Small placards posted about in conspicuous places dispel the idea that tuberculosis cannot be cured, and cheer the patients with helpful hints.

There are, at present, 160 patients in the sanatorium, of whom 50 are women and 110 are men. The total capacity is 185 beds, and when contemplated additional buildings are erected quarters will be provided for 300 patients. The cost of the present structures together with the grounds of 408 acres was more than $300,000 net, including the equipment.

Occupational therapy was taught previous to the fire which destroyed our service building. When the new building is equipped and occupied, the temporary service building will be converted into a recreation building, work room and occupational therapy quarters where ambulant patients may go for an hour daily and engage in some useful and instructive handiwork. During the brief period our patients engaged in occupational therapy, much interest and rivalry were manifested. The proceeds from sales were divided with patients on a fifty per cent basis, each one receiving his money when collected from sale of the article. Those unable to go to the work rooms are allowed to sew and do needle work such as embroidery and crocheting in bed and it is surprising the interest taken and amount of fancy work turned out. This is their own to dispose of as they see fit. The work brings some slight financial returns which are much appreciated, but perhaps the most important feature is the fact that the patient has a tryout which helps to season and harden him physically for his career after recovery has taken place.

A cluster of Weimar cottages in their mountain setting

The MODERN HOSPITAL

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HOSPITAL ADMINISTRATORS OR COMMUNITY ORGANIZERS?

COMMENTING on the report of the committee on the training of hospital executives (see page 512), Mr. John R. Howard, Jr., who has had a number of years of experience in the adminstration not only of hospitals but also of community health and social welfare activities, takes issue with the report in its recommendation that the hospital superintendent of the future be trained to assume the role of community organizer in health matters. We believe his point is well taken.

Let us assume that a man is so trained and finds himself appointed director of a 200-bed hospital in a community of 80,000, which has three other hospitals, one, let us say, a municipal hospital of 100 beds and two small privately owned institutions of 50 beds each. One needs little imagination and less experience to realize how utterly impossible it would be for the director of the 200 bed hospital to organize the health activities of that community. A mere statement of the situation carries its own answer. Or, let us assume that the superintendent educated as a community organizer in health matters finds himself at the head of a 300 bed hospital in one of our larger cities. Is it humanly possible for him to do more than guide the administrative machinery of such an institution if he does it really well and conscientiously? If by some wide stretch of the imagination he should find circumstances such that he could function in his immediate community as the organizer of its health activities, it would be only because he has an assistant who in fact functions as the superintendent of the hospital, thereby leaving him free to work in the community at large as an organizer. Or, let us assume once again that the superintendent educated as a community organizer finds herself the head of a small 50 bed hospital in a community in which her institution is the only one. It is barely conceivable that here she might function as a community organizer. On the other hand, we are inclined to feel that the limited funds at the disposal of the hospital would force her to serve not only as the superintendent of the hospital but as head of its nurses' training school, as chief dietitian and perhaps as housekeeper. Under such circumstances what time or strength would she have in reserve to organize the health activities of the community at large.

Furthermore, as Mr. Howard very properly points out, if the hospital is given control of the organized care of the sick in their homes, the hospital will grow; trustees and doctors will center their interests there; the question of whether

a patient should be cared for in the home or in the hospital will be carelessly and selfishly determined; and the care of the patient in the home, and of the home when the patient goes to the hospital, will suffer, for "a hospital because of its visibility has a capacity for absorbing time, interest and money which is prodigious."

That the hospital executive should have a sufficient knowledge of the social sciences, public health activities and other kindred subjects to enable him to cooperate sympathetically and intelligently with any agency that may be established for the purpose of coordinating the health activities in the community is freely conceded; but that he should be trained to do the actual coordinating is to train him for a function that he will have little opportunity to exercise.

That the health activities of many communities sadly need coordination none will dispute, but in our judgment, and this judgment finds its basis in actual experience, this can best be done by some such plan as that which has been adopted in Monmouth County, N. J., where, through the agency of a county organization which includes in its membership the social and medical interests of the county, all the health, charitable and educational agencies, concerned in the maintenance of individual and public health, are successfully coordinated.

But when you train a man to act as the executive of such an organization you are not training a hospital superintendent.

YALE ESTABLISHES CHAIR OF HOSPITAL ADMINISTRATION

IT WAS our pleasure to announce in the November issue of THE MODERN HOSPITAL the appointment of Dr. Willard C. Rappleye, one of our associate editors, as director of the New Haven Hospital, the teaching institution of Yale University and professor of hospital administration at Yale Medical School. Dr. Rappleye, it will be recalled, was secretary of the committee on the training of hospital executives which recently published its report on this vital subject. Before acting as the secretary of this committee Dr. Rappleye was for a time director of hospitals for the University of California.

The establishment by Yale University of a chair of hospital administration marks another important step in the founding of a school of hospital administration with a well-rounded curriculum and a full complement of professors, such as one may find in a well developed school of engineering or even in some of the better organized schools of social work.

The movement for a school of this type had its inception, as most movements of this kind have, in the realization of the need of definite education in hospital administration on the part of a few far-seeing individuals.

Discussion, for the most part nebulous and desultory, followed, with the inauguration here and there, such as at Massachusetts General Hospital, Bellevue Hospital, Presbyterian Hospital of Chicago and Grace Hospital of Detroit, of more or less thorough courses in hospital administration. The opportunities these courses offered for training were usually embraced by graduate nurses in order to fit themselves to undertake executive positions in small institutions. Obviously these courses could not do more than touch upon the simpler elements of hospital administration, and were not framed to give thorough training in the diverse and complicated problems that executives of larger hospitals are called upon to meet. Here and there, moreover, isolated courses on some phases of institutional management have been given by experts in their field.

But the first attempt in this country to place the training of hospital superintendents on a university basis was made by Dr. A. C. Bachmeyer, superintendent of Cincinnati General Hospital, in the fall of 1919. At that time a division of hospital administration was added to the department of industrial medicine and public health in the college of medicine of the University of Cincinnati. Through this division a year's course in didactic, seminar and practical training in hospital administration was given, using the facilities and personnel offered by the University's college of household arts and economics, college of medicine and school of nursing and health. The course unfortunately was inaugurated too late to give it the necessary publicity; consequently but one student enrolled that fall. In passing, it is worth noting that this student, a graduate of but two years' standing, is now superintendent of one of the most prominent of the southern hospitals. It is greatly to be regretted that owing to lack of funds this course thus far has not been repeated.

The establishment of a chair of hospital administration and the appointment of Dr. Rappleye as its encumbent encourages us to believe that there will be worked out at Yale University a well-rounded course for the training of hospital administrators, a course which may ultimately develop into a school of hospital administration, one of the integral units of Yale University. For practical training its students will find a wealth of material not only in the hospitals of New Haven and its nearby cities, but more espe-

cially in the splendid and diversified hospital facilities of Boston and New York.

SUPPLIES DETERIORATE

ALTHOUGH four years have passed by since the World War drew to a close, job lots of hospital supplies are still being offered; in many instances of questionable quality. Some hospitals, in their efforts to economize, are purchasing these questionable lots, believing they are of present standards and 100 per cent perfect.

Many of these goods were manufactured under war time conditions and special requirements. Manufacturers were called upon to change their processes in order to conform to government specifications. Containers, the suitability of which has been determined by years of experience, were not accepted. Supplies have often been improperly stored in government warehouses. Since even iron and steel will not remain unchanged during a period of five or six years, it is not to be supposed that such delicate articles as chemicals, surgical sutures and surgical dressings would retain their integrity. Instances are known where tablets and pills have disintegrated, where liquid preparations have fermented or precipitated, where chloroform has decomposed and where sutures have lost their tensile strength and even their sterility.

Before purchasing supplies of this character, the least hospital superintendents can do in the interests of the patients in their institutions is to subject them to rigid tests and see that the shipments conform to sample.

A VALUABLE WORK OF REFERENCE

AS THERE are six issues to each volume of THE MODERN HOSPITAL, it has been our custom to publish in the June and December numbers a fairly complete index of the contents of each volume.

Heretofore this index has usually been bound in the magazine just after the text matter. Beginning with this volume, it will be found in the magazine next to the back cover.

There is a constantly growing number of our readers who find it desirable to bind THE MODERN HOSPITAL. To these people the index is an indispensable aid in giving ready access to the contents of each volume. We bespeak a more general use of the index by our readers who, in view of the limited literature of the hospital field, will find the bound volumes of the magazine valuable works of reference.

The first wealth is health.—Emerson.

The Christmas season offers a most appropriate time for the American Hospital Association to send you a message of good cheer, and an expression of a sincere desire to help you in solving your many problems during the year.

Jesus, the "master physician," healed all manner of disease and so His work is being perpetuated in our hospitals. No institution of similar type is carrying on such self-sacrificing work for suffering humanity as the hospital; therefore all of you who are engaged in the work may rest assured that the Divine Healer will watch over, guide and bless you.

There are three great institutions in our land that are responsible for the success and happiness of our people: the church for our spiritual guidance and happiness; the school for our educational welfare and happiness; and the hospitals for our physical well-being and happiness. Without healthy bodies, there can be no spiritual, educational or physical success or happiness; therefore is it not fitting at this Christmas time to call the attention of our citizens to an opportunity for Christmas service this coming year through acts of generosity to our institutions, they as well as workers within the hospital may share in the happiness that comes through service of human kindness to our fellowmen.

Let us forge ahead, holding fast to the Christmas spirit, "Peace on Earth, Good Will toward Men."

Asa S. Bacon

President, American Hospital Association.

STICK TO YOUR JOB

Jumping around from one job to another will ultimately drag any man down to the bottom of the ladder and make him a stepping stone for the real stickers in the game of business. When you feel the fancied greater opportunities of other fields tugging at your sleeve, just hold a short communion with yourself and remember that it's the man and not the line which achieves success. You will then decide that there is nothing better than the work you are doing and that you make your own opportunities by the spirit you put into your task every day. The fellow who attempts to dodge that fact is only kicking progress in the shins.

THE PRESIDENT SENDS GREETINGS TO THE HOSPITAL FIELD

THE WHITE HOUSE
WASHINGTON

November 7, 1922.

My dear Mr. Weber:

It is a pleasure to avail myself of your invitation to extend a Christmas greeting to the devoted men and women who constitute the staffs of hospitals throughout the country; and along with these, to the multitude of others whose charitable purposes and fine generosity have made possible the maintenance of these splendid institutions of mercy. Whether the hospitals be viewed as technical or as humanitarian establishments, the hospital system must be recognized as one of the best fruits of our Christian civilization, a practical contribution of grace and goodwill to the amelioration of suffering and the betterment of life.

Most sincerely yours,

Warren G. Harding

Mr. Joseph J. Weber,
The Modern Hospital,
22 East Ontario Street,
Chicago, Illinois.

President Harding, at the invitation of the editor of THE MODERN HOSPITAL, has sent the above Christmas message to the hospital workers of the United States and Canada.

THESE JUDGES WILL SELECT PRIZE PLANS OF SMALL HOSPITAL

Above, Architects William B. Stratton and Clarence H. Johnston; center, Dr. S. S. Goldwater; below, Superintendents Asa S. Bacon and Adelaide M. Lewis

JUDGES OF ARCHITECTURAL COMPETITION NAMED

WITH one hundred architects at work on their designs and with a steady influx of new registrations, the value to the field of THE MODERN HOSPITAL'S $1,000 prize competition is definitely assured.

Seven countries have evinced interest in the architectural contest, with the latest request for more detailed information from northern Africa, the French colony of Algeria. In the United States the high points of interest, as evidenced by the number of competitors, are New York, Massachusetts and California. Every section of this country is now represented in the competition so that if many of the designs submitted are deemed by the judges worthy of publication, each locale will find several plans adapted to its use, with only minor modifications necessary to suit individual conditions.

Two months remain before the final date for submitting designs, and registrations will be accepted at the Chicago office up to and on December 15. This will allow foreign architects time to announce their intention of entry, after careful translation and study of the general program.

With this issue, official announcement of the jury of award is made. These judges, selected from leaders in the field of hospital administration, architecture and nursing, are:

Dr. S. S. Goldwater, superintendent of Mount Sinai Hospital, New York, hospital consultant, and former commissioner of health of the city of New York.

Asa S. Bacon, president of the American Hospital Association, and superintendent of Presbyterian Hospital, Chicago.

Clarence Howard Johnston, Minnesota state architect, former director of the American Institute of Architects, former president of the Minnesota chapter, and designer of the Charles T. Miller Hospital, St. Paul; St. Mary's Hospital, Rochester, Minn.; The City and County Hospital, St. Paul; various hospitals at Minnesota state institutions and many college and private hospitals.

William B. Stratton, of the firm Stratton and Snyder, architects of the Detroit General Hospital; the University of Michigan Hospital at Ann Arbor, Mich.; the Municipal Tuberculosis Hospital at Detroit; the Saginaw Women's Hospital at Saginaw, Mich.; Frederick Stearns Chemical Laboratories; Wayne County Juvenile Court and Detention Home; Children's Tuberculosis Hospital and Summer Camp; and numerous other hospitals of the Middle West. He is a fellow of the American Institute of Architects, a member of the Detroit Building Commission and a trustee of the Detroit Museum of Art.

Miss Adelaide M. Lewis, R.N., superintendent of the Kewanee Public Hospital at Kewanee, Ill.; graduate of the Hospital of the University of Pennsylvania at Philadelphia; postgraduate of the Presbyterian Hospital, Chicago; former superintendent of the Presbyterian Hospital, New Orleans.

JURY OF AWARD

S. S. GOLDWATER, M.D.
Director, Mount Sinai Hospital, New York

ASA S. BACON
President, American Hospital Association

CLARENCE H. JOHNSTON
Minnesota State Architect, St. Paul

WILLIAM B. STRATTON
Stratton and Snyder, Detroit

ADELAIDE M. LEWIS, R.N.
Superintendent, Kewanee Public Hospital, Kewanee, Ill.

The jury will meet in Chicago to consider the merits of the respective designs the month following the formal closing of the contest on February 1, 1923. Selection of the prize-winning drawings will be made by secret ballot and majority vote. In reaching its decision the jury will consider the merits of the designs, the merits of the plans from the standpoint of economy in construction and efficient operation, the integrity of the presentation and such other points as it may deem best.

After the plans have been judged the architectural adviser, Mr. Richard E. Schmidt of Chicago, will open the sealed envelopes which contain the names of the winners. Three prizes—$500, $300 and $200—and two honorable mentions will be given.

To Consider Organization and Equipment

Of further significance in THE MODERN HOSPITAL'S contribution to the small hospital field will be a series of articles on the equipment and organization of a community institution. Committees, selected from both large and small hospital administrators, already are at work on this study.

In connection with the competition this issue includes several articles having a direct bearing on small hospital construction; among them are: "The Planning of the Small Hospital" by Edward F. Stevens, Boston architect; "The Technique of Planning Private Rooms" by Richard Resler, New York architect; and descriptive articles on the Mary Imogene Bassett Hospital at Coopertown, N. Y. and the Evans Hospital at Columbus, Nebr., two new community institutions.

COMMENTS ON REPORT OF COMMITTEE ON THE TRAINING OF HOSPITAL EXECUTIVES

By JOHN R. HOWARD JR., Superintendent, New York Nursery and Child's Hospital, New York, N. Y.

THE report of the committee on the training of hospital executives, presented so ably by Dr. Willard C. Rappleye before the American Hospital Association, enjoyed little critical discussion by the convention. This was due partly to the fact that our forceful, emphatic secretary prefaced the discussion by reading the "unanimous" vote by which the trustees of the association gave their "unqualified" approval to the report, partly to the fact that Dr. Rappleye answered many criticisms in advance, and partly to his statement that the report contained nothing new.

This is a great pity, for the report does contain something new. As hospitals have to concentrate upon the universe within their walls, it may not sound new to them to be spoken of as "a coordinator of activities—professional, economic and social—in their application upon the problems of health," or to be told that their administration must be "based on the community as the unit of operation." But to those who have worked in public health fields outside of the hospital, who have attempted to organize communities in fields other than health, or who have undertaken the much-needed but no-where wanted function of coordination, the prospect of the hospital executive coming out of his hermitage to assume the role of "community organizer in health matters" is not only new, but startling.

When social welfare bodies, special or general, feel this urgency toward coordination, they do not suggest the reeducation of the heads of infant asylums, almshouses or prisons. Perhaps that is just what they ought to do, but they do not.

Where would the preventive work in the field of tuberculosis be if it had been left to the heads of tuberculosis hospitals, or even if it had been organized about such institutions as the "common ground?"

An administrator is rarely an organizer, and an organizer is rarely a safe administrator. As for the coordinator, he is a genius. Training will not produce him.

The report deals with two distinct needs. "Over 80 per cent of the hospitals in the United States are institutions of 100 beds or less," nearly 90 per cent of which are in communities of 50,000 or under; 10 per cent are institutions for nervous and mental diseases. That leaves 10 per cent, about 700, which are hospitals of over 100 beds in our larger cities.

The demand for the training of hospital executives undoubtedly originated from the needs of these larger hospitals. The training which this report proposes for hospital executives is nine months of academic work and six months of practical work. The "academic-demonstration-conference" course is valued as follows:

1.	Public health	20%
2.	Social sciences	15%
3.	Organization	15%
4.	Hospital functions and history	10%
5.	Business science	10%
6.	Institutional management	10%
7.	Personnel administration	5%
8.	Community hospital needs	5%
9.	Physical plant	5%
10.	Jurisprudence	5%

Must Educate Trustees as Well

Check which subjects a hospital board of trustees would look for in a prospective candidate for superintendent! What is there left? There will remain anywhere from 35 to 50 per cent excess. This indicates, perhaps, only that hospital boards need education as well as executives. This the report recognizes in its reference to "the present somewhat general conception of a hospital as a hotel for the sick with the superintendent an exalted steward or clerk, with little voice in shaping policies and less responsibility in executing them."

The unawakened board and the uneducated executive form a vicious circle that it is difficult to break in upon. If we begin training executives for this enlarged conception of the hospital, ninety-nine hundredths of them will find themselves stultified by the requirements of their trustees. The born leader, the fighter, may win through, but most will have their enthusiasms killed and their educated ideals crushed by the centripetal forces of their prescribed duties and restricted responsibilities. A hospital executive that hitches his wagon to a star should hitch it to the kind that shine in the vault of the Grand Central Station, New York, *inside the building*. Otherwise he is likely to wake up to find someone else driving the wagon.

Teach Executives Preventive Medicine

Train the hospital executive by all means, but train him for something he will have some chance of accomplishing. Train him how to run a "hotel for the sick." Goodness knows, he needs it. Teach him that it is more important to check disease in the dispensary than to cure it in the hospital. Not one superintendent in ten and not one board of trustees in a hundred pays the slightest attention to the dispensary, because the financial outlay is negligible! Teach him that not more hospital beds but fewer sick people is the aim; that it is more important to keep ten patients, who have been treated, well by "follow-up" than it is to treat twenty more; and that in checking, or curing, disease, or preventing relapse, the condition of the patient's home is often more vital than that of the patient. This is but the A. B. C. of modern medicine, but until it has become a recognized and emphasized part of the routine of more of our city hospitals, it seems premature to train hospital executives to undertake more than already lies at their doors, neglected. As for the hospital as an educational institution—medical, nursing, and hygienic—here lies a field of tremendous opportunity to which most hospital executives come with absolutely no preparation.

When it comes to the hospitals of less than 100 beds in our smaller communities (80 per cent of all hospitals), we have a different problem. First we have the care of the sick, and the report tells us that "a large proportion, of illness occurs, is cared for and should continue to be cared for in the home." That organized care for the sick (and their families) in their homes—far beyond what the visiting nurse can afford—is a vital need, is true, and that it is practicable has been demonstrated; but just as sure as the hospital is given the control of such organization, the hospital is going to grow, trustees and doctors are going to center their interest there, the question of whether a patient should be cared for in home or hospital is going to be carelessly, or selfishly, determined, and the care of

the patient in his home, and of his home when the patient goes to the hospital, is going to suffer. A hospital, or any institution building, because of its visibility, has a capacity for absorbing time, interest and money, which is prodigious.

Social Agencies Not Easily Coordinated

As for the hospital acting as coordinator of all the community agencies and activities pertaining to health, such a proposal simply overlooks or underestimates the amazing individualism and proprietorship of the average social agency, however small. There was described at the American Hospital Association convention, "How a New Jersey County and its Hospitals Got Together." It was an extraordinarily interesting portrayal of just what the committee on the training of hospital executives wants to see come about, the coordination of all the agencies—public and private, health, charitable and educational—concerned in the maintenance of individual and public health. The progress made in Monmouth County in a few years, if correctly reported, was made through the agency of a county organization which included in its membership all the varied *and vested* social interests of the county. Such progress could never in the world have been accomplished by the hospitals, or any other individual agencies, enlarging their functions or assuming the role of coordinator; first, because no hospital board (that most of us know) would have had the vision; secondly, because the other agencies would have been jealous of their rights. Just as well play coordinator to a hornet's nest.

But the report tells us that 56 per cent of the counties in the United States have no hospitals at all. What is to become of their health needs? Build them hospitals, consigned to the trusteeship of educated boards and administered by trained executives? Shades of Charles Lamb's roast pig!

Undoubtedly there is vast need for coordinated "health service." How it will ever come in our big cities is a matter of conjecture. Meantime, let us train for the city hospitals executives drilled in business administration, educated in the scientific care of the sick and in the importance of "follow-through," qualified to be the full-fledged executive officer of the governing board, and ready to get the hospital in line wherever the movement toward coordinated health service appears.

For our smaller hospitals, in smaller communities, much the same program holds, except that here the executives will of necessity be women, and except that their opportunity for encouraging or inaugurating a united community health program will be much better. For them there *is* need of most of the subject matter outlined in the proposed course of training.

County Health Organizations Needed

For the counties without hospitals, a county health organization is needed (by whatever name). The fact that several such organizations have failed to make progress in several years proves nothing but that the problem is difficult. A dozen attempts should be made and a dozen years given them to succeed or fail in. Where hospital beds are needed, such organizations can see that they are provided, but their number and their use should be developed by the community organization according to community needs. Where these beds grow to a sizable hospital, it had better be separated, or it will gobble up the more vital but less obvious service.

While such experiments are being tried, let us by all means have experiments where the hospital does try to enlarge its function and its field. Perhaps it will prove to be as successful as the report expects. In small town and rural communities it is undoubtedly easier to introduce new ideas through existing agencies, or their executives, anything new being viewed with suspicion. It is not certain, however, that an educated school principal could not accomplish more in public health measures than an educated hospital executive, and the school we have in 100 per cent of our counties, not 44 per cent.

Dr. Rappleye told us that one of the criticisms of the report was that it was too short. It is possible that an extended record of the Committee's investigations would reinforce its conclusions. The report as published carries conviction chiefly because of the origin and make-up of the committee. This is not as it should be. The subject merits discussion. The exhortation of Mr. Daniel D. Test, that we should not criticize it but get behind it, is good politics but poor statesmanship.

A PRACTICAL INTERPRETATION OF HOSPITAL STANDARDIZATION

Many hospital trustees and executives are asking themselves today, "What does hospital standardization offer and provide in the minimum standard requirement as laid down?" There are three things that should be kept in mind:

1. The getting together in the hospital of a group of doctors who are unselfish, honest and prompted by a spirit of service, who keep a close supervision over the medical work of the hospital by meeting at regular intervals to review and discuss same, and by working harmoniously with an internal organization which stands between the patient and danger or incompetent care.

2. The keeping of a complete record of every patient, such record to embody all the facts of practical and scientific interest in connection with the case, this record to be a check-back on the way the case was handled and on results obtained and, in addition, to meet the many other advantages so well known to all, and very particularly, as a valuable medico-legal record in many instances.

3. Making provision for all facilities necessary for the assistance of the doctor in arriving at an intelligent diagnosis in the care of the patient and in the more effectual treatment thereof by such means as laboratories can furnish.

Trustees and hospital executives may further ask the question: "What has hospital standardization done for our institution through the adoption and enforcing of the minimum standard requirement?" This, indeed, is a long story, and only a few advantages can be enumerated—

1. Hospital standardization has establsihed a more intelligent control of the medical work of the hospital.

2. Hospital standardization has established a competent medical audit of the work in the hospital.

3. Hospital standardization prevents criminal abortions and illegal operations, which formerly and otherwise could be carried on without check in the hospital.

4. Hospital standardization has reduced to a minimum incompetent and unnecessary surgery in the hospital.

5. Hospital standardization has stimulated everyone in the hospital to a deeper realization of their obligation to the patient.

6. Hospital standardization has made the hospital safer for the care of patients.

7. Hospital standardization has increased scientific and clinical interest in all branches of medicine in the hospital.

8. Hospital standardization has saved lives in the hospital.

CHRISTMAS HOLIDAYS IN THE SOUTH

That the Christmas spirit is by no means dependent upon the stimuli of snow, ice and frosty air is proved to Northerners by the following accounts of holiday celebrations in the hospital and training schools of the South. As one southern superintendent declares, however, it does take ingenuity and imagination to prepare a Christmas entertainment that does not seem like a May party.

Although the "white Christmas" is a delight to Northerners, they may not share with the nurses at Touro Infirmary, for example, the joy of picknicking in the woods while they gather mistletoe, holly, ferns and other greens for their own trees.

Some interesting Christmas observances are chronicled below.—EDITOR.

Christmas at Houston Baptist Hospital

By ROBERT JOLLY, M.D., Superintendent

As there has not been snow in our part of the country for about twenty years, and as many of our people, not only the children but the grown-ups, have never seen a real white Christmas such as our friends in the north have nearly every year, it taxes the ingenuity and the imagination to prepare a Christmas entertainment that will not seem like a May day party. Please do not think that we do not observe and enjoy Christmas to the fullest, but to those who are accustomed to freezing weather and deep snows, it seems mighty "summery" for Christmas.

Last Christmas Eve we had two entertainments, one on the seventh floor in the children's department, for the children and such of the patients as could come, and another over in Sunshine Hall for the nurses, the doctors and friends of the hospital.

A week before, our engineer had gone out into the country and procured the trees, and had hidden away the one for the children, so that it could be prepared before the children should see it. The one for the nurses was set up in Sunshine Hall, and the supervisors spent their spare time decorating it and the room.

I might explain that Sunshine Hall was intended for a laundry, but plans were changed after the building was erected, and our superintendent of nurses, Mrs. J. P. Burnett, transformed it into a beautiful reception hall.

The musicians of Houston every Christmas Eve form themselves into carol bands and, after the great Christmas tree in the heart of the city, go to the hospitals and institutions for shut-ins and sing outside of the buildings.

Christmas eve in a southern hospital children's ward

At seven-thirty, when the children and all the patients who could had gathered in the children's department, the first warning they had of the festivities was the strains of "Holy Night" from the singers seven floors below. Need I say that this song is as touching on a warm night as it is on a night when the mercury is at zero. In a moment perfect quiet reigned, and until the singers had finished it and two other songs, the hush was as intense as it must have been on a night long ago when angels sang to the shepherds.

When the singing had ceased, the tree was rolled in. When the children saw it, laden with presents, and saw Santa Claus come rushing in they forgot all about angels, and bedlam broke loose. We did not torture them by having a program, but got down to business at once. The Shriners of the city send their cripples to our hospitals. They did not forget their patients but gave lavishly to each. Those of us who are not ashamed to cry found the tears wetting our faces as the "crips" in their beds tried to partake of the festivities. Oh, they got the first attentions, and their enjoyment did not suffer much, if any, because of their immobility or their sickness.

Helping Santa

When the fun was over, the nurses and officers started for Sunshine Hall, but those patients who could get about were not going to miss anything, and so, when we got there, they were already there. Of course, we had to take "John the Baptist," the five-year old deaf and dumb boy whose mother left him at the hospital when he was a day old and never came back for him. The hospital has cared for him until he is now able to go to school. He bosses that bunch of women, and he was supreme that night.

This time our students sang the carols out in the hall, and then followed a beautiful and interesting program rendered by the nurses and friends. Then Santa Claus came and—well, our hospital never has based its reputation on quietness, but if it had it would have lost it all that night. All of the presents which had come to the hospital for the nurses had been kept in the office to be distributed on Christmas Eve, so that with the gifts from the outside and the gifts within there was a huge stack. The friends and guests enjoyed the occasion as much as did the students.

We then served refreshments to those who had not filled up on candy, and the guests began to leave for their homes, and there to prepare for their own festivities. In a few minutes the place became again like a hospital, to remain so until next morning, when the patients had "theirs." But that is another story.

By the way, we lost "John the Baptist," and after searching frantically for four or five minutes the little

rascal was found asleep on the floor behind the Christmas tree, with both arms chock full of presents. No, he did not get a spanking.

Flagler Hospital Celebrates

By A STUDENT NURSE

Christmas in a hospital sad and lonely? Never. Why last year our Christmas at Flagler Hospital, St. Augustine, Florida, was stuffed tighter with fun and real pleasure than your Christmas turkey. It was the first to be celebrated in our beautiful new building. Nature's gift was an ideal day; the air just crisp enough to fill one with pep a plenty, and with some to spare for those less fortunate.

You can't imagine any place more "comfy" and cheerful than our lovely solarium, overlooking the beautiful Bay, with the warm sun smiling through each window from its blue Southern sky. Add to its natural beauty a gaily decorated Christmas tree, banked with baskets of fruits and delicacies well laden with gifts—very humorous gifts. Surround that bright tree with happy, smiling nurses and interested, expectant patients delighted to join the fun and you can realize it was a joy to see.

True all patients were not so fortunate. For those confined to their rooms a special guest of their choosing was invited to enjoy dinner with them. During the meal a huge tray banked with moss and fruit was passed. Each patient pulled a tiny ribbon which drew an amusing gift from the bank of fruit.

After our day of pleasure-giving we went to nurses' home happy and anxious to open packages from home. There we found the very brightest, gayest tree possible, heavily burdened with most interesting and mirth-inspiring gifts. Every one was brimming with good cheer and Christmas spirit. The doctors and superintendents, were there to enjoy the fun with us. The Womans' Auxiliary, ever mindful of little pleasures and comforts, saw that everything was done to make the day one to remember pleasantly.

Holidays for Touro Nurses

By LEONA ANCLIN, Student Nurse

The Christmas holidays are joyful ones for the Touro Infirmary nurses at New Orleans. A vacation of one week is allowed those who can conveniently go to their homes in that length of time. This vacation is taken either during the week of Christmas or New Year.

A vacation allowance is given to each nurse. Some of our nurses are so far from home that we must afford amusement in our Nurses' Home for them during the holidays. We have nurses from far away Switzerland, Russia, Honduras, and the remote sections of our own country.

It is the desire of our directress and other staff members to arrange a holiday program that will make glad the hearts of the remaining nurses and dispense with that longing for home that is so natural to all during the holidays. I will, describe to you our last Christmas at Touro, endeavor to picture mentally what a happy season it was for all of us. Instead of bemoaning the fact that a large portion of our time must be spent on duty, the Christmas spirit was everywhere and we found pleasure, not only in anticipation of our coming celebration, but in our work as well.

The members of our staff, together with a few of our student nurses took a glorious afternoon off and had a regular picnic in the woods, in search of evergreen decorations for our great dance hall, parlors and dining quarters. A tree large enough to accommodate gifts for over 100 nurses was the center of attraction on Christmas

Santa and his hospital helpers have been lavish with these patients

Eve. After our exhilarating afternoon in the woods, where we romped like school children instead of prim, professional women, we brought in a most generous collection of mistletoe, holly, ferns and other lovely sprays. Then came the joy of decorating.

With hammer and nails, the nurses transformed our home. All packages, except perishable, that were received during Christmas week, were taken for the Christmas tree so that along with our gifts from the hospital, we had many glad surprises from home and our outside friends. Our staff doctors never forget the nurses at Christmas time. Our tables are strewn with candies and numerous delicacies as tokens of their thoughtfulness. Among our presents from Touro, each nurse received a beautifully bound book entitled "The Soul of the Surgeon," by the chief of our surgical staff,—Dr. Rudolph Matas, a gift which we prized very highly. One of the nurses assumed, very tactfully, the role of Santa Claus much to the amusement and delight of all. Following the distribution of the presents, we danced merrily until long past the midnight hour. Each nurse was allowed to invite a friend for the occasion.

A Baylor Hospital Christmas

The waking moments of the patients at Baylor Hospital, Dallas, Texas, were greeted by Christmas carols, sung by a group of nurses throughout the buildings. This is an annual custom. With the special dainties on the patient's trays were placed sprigs of Christmas greenery. In quarters where there were children, Christmas trees were provided, while all the general wards were brightened by various holiday trimmings. In the main front hall was placed an ornamented tree, that met the eyes of all visitors on entrance. Later in the day a choir from one of the large city churches serenaded the hospital with Christmas music.

On Christmas Eve the nurses enjoyed their special festivities with a large tree in their chapel. This is always an occasion of universal humor. Take-off gifts were given to doctors nurses and other personnel of the institution, with gentle gibes at individual peculiarities and reminders of amusing happenings of the year. A similar spirit pervaded the whole program including the music. The "fake" gifts were presented and the humorous cards accompanying them were read, by a typical Santa Claus. In this occasion were also announced the gifts by doctors and others of subscriptions to various magazines for the ensuing year provided for the nurses in training.

AN ADMINISTRATIVE PATHOLOGICAL SERVICE

By MYRTELLE M. CANAVAN, M.D., Pathologist, Massachusetts Department of Mental Diseases, Boston.

SYSTEMATIC reports of accidents, assaults and injuries, and sudden or violent deaths were not made to the Massachusetts state board of insanity, now known as the department of mental diseases, until 1913. During previous years, many complaints regarding accidents and injuries in state hospitals were lodged with the governor, who had no one to whom to refer these complaints except the executive chairman of mental diseases, and any untoward accident in a hospital was explained to the boards of trustees and families and otherwise was not always a matter of record.

Dr. L. V. Briggs it was who conceived the idea that reports of accidents, assaults and injuries occurring in state hospitals should be made to the state board of insanity, that an officer from the department should investigate them and that the pathologist's duties should be extended to a subordinate who would investigate the sudden, unexpected or violent deaths.

These crystalline conclusions were precipitated when it was reported from an irate family out of the state that the dead body of a relative had been received by express with multiple fractures, with no resultant explanation from the hospital.

Report Is Designedly Tedious

A formal report of such cases with the exact date, names of patients and witnesses, hour of occurrences and methods of investigation and attempted mitigation shows clearly to the superintendent where any error lies in the wards, either in ward construction, in personnel or in the observation and care of the patient. The mere tediousness of a detailed report helps everyone to determine against its frequency. Dr. Briggs concluded that the more trouble it was to report accidents, the fewer there would be and that hypothesis was borne out in the down-curving of the number of accidents from 1914 to 1919, during which time they fell from 346 to 208 in 1919.

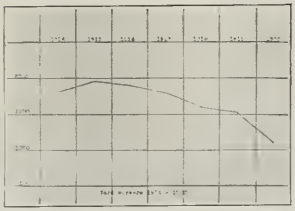


Chart A
Ward Workers—1914-1920

In Chart A the number of ward workers in the hospitals has declined nearly half from 1914-1920; levelled off in numbers by the war when the morale of the stay-at-homes was high and the spirit good in combining efforts for victories, they were again ready for movement and change when the pressure was removed. A standard quota of one attendant to eight patients in acute receiving hospitals and one to eleven in custodial hospitals was inaugurated in 1919 by the commissioner of the department of mental diseases.

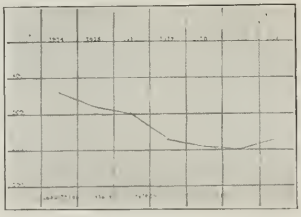


Chart B
Casualties in State Hospitals, 1914-1920, inclusive

In 1920 the ward personnel, Chart A, shows that the workers were fewer in number, and the accidents, Chart B, were again curving upward. This is difficult to explain unless one remembers that there might be teasing spirits in the nursing force, that there might be a reaction from the war in newborn ideas of discipline and the importance of the individual. The supply of unemployed was at a low ebb in 1920 and superintendents were reduced to taking anyone who would come for work in the hospitals.

Untrained Attendant May Provoke Attacks

It is hard to conceive that any intended violence from an employe contributes to the injuries of the aged or bedridden: it is not so difficult to believe that the younger men or women may provoke attacks. The attitude of an untrained attendant toward a spitting praecox, a lazy imbecile or an obscene paretic is reviewed not without sympathy for their probable reaction, judging by normal standards of behavior. It is easy to advise attendants that the patients are sick mentally and that they transfer their delusions to the object seen, but it is hard for them to remember it when the moment for action arrives. The writer distinctly remembers and clearly reconstructs the feelings entertained when a patient fastened her hand in her hair some years ago.

The estimated contacts made between nurses and patients in the Massachusetts state hospitals in a year are in the many thousands, since they include the baths, the meals, the duties involved in rising and retiring, the night attention, the entertainments, the walks, the ward work, the many incidentals occurring at holidays, and attendance upon visitors, the examinations, the weighing, the clothing, the smoothing out of misunderstandings between patients; all these contacts and so relatively few accidents speaks well for the plan of management, the tact of the nurses, or they indicate the indifference of the majority of patients in the hospitals.

Nurses in state hospitals not only have to follow physicians' orders but have to anticipate the patients' objections and whims. For nurses who are in training and have not the incentive of brevity in their care of patients, it compels admiration that they so consistently keep as high level of moral fortitude as they do.

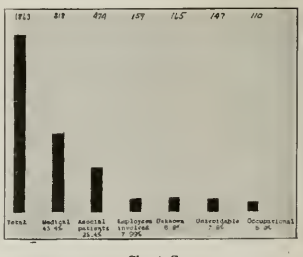


Chart C

In Chart C the graphic method shows that in 1863 accidents, medical reasons (convulsions, muscular weaknesses, ataxia, etc.), contributed to 818 or 43.4 per cent; that the asocial acts of patients themselves contributed 474 or 25 per cent; occupational activities contributed to 110 or 5.9 per cent; 165 or 8.8 per cent were unknown in origin; and 147 or 7.8 per cent were unavoidable. In 115 of the 159 incidents, employes could

actually be held responsible, and 15 were arrested, 63 discharged, 29 reprimanded and eight left before they could be interviewed, practically acknowledging their guilt.

It must be a source of pride that employes are involved only in about 8 per cent of the cases and actually to blame in 6 per cent or 115 instances.

The comparison of medical personnel, Chart D, and ward aid, Chart A, with a number of casualties, Chart B, makes an amused comment involuntary. The less the contact, the fewer accidents (1918-1919, but even less workers in 1920 shows again a rise in casualties, so that perhaps the "irreducible minimum" had been reached in 1919. Of course, the character of the attendants may have something to do with all this.

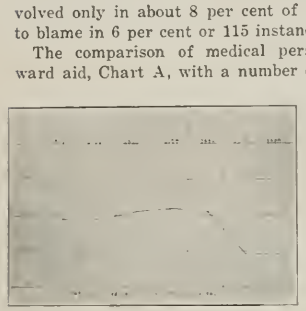


Chart D
Medical Personnel, 1914-1920

It was suggested that occupational therapy might be credited with helping reduce the patients' "excess energy," but for the most part the type of patient who is prodded into activity in the occupational departments is not one that usually gets into difficulties.

More Accidents in Daytime

The curve in Chart E representing 1,665 accidents in the twenty-four hours shows graphically what experienced administrators know, namely, that the majority of the accidents occur in the daytime (5 a. m. to 7 p. m.) and in that period the peak is at 7 a. m. and another at 3 p. m. It is to be considered that more accidents will show their effects in the day than in the night, and that at the time reports are being made the sum total rises.

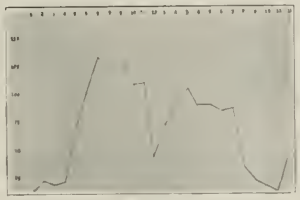


Chart E
Distribution of 1,665 Accidents in 24 Hours

If one considers the major itemized activities in a hospital routine, the following develops: At 5 a. m. the night attendants make their last round and write their reports and are released at 6:00 when the day force arrives, but they have not had their breakfasts, the natural cheerfulness of dispositions has not asserted itself in either patients or attendants. Who, if not this group, are diagnosable as possessing the neurasthenic type of mind? Neurasthenia plus hunger, craving stimulant, minus morning grooming presents edges and angles for friction. What happens? Groping for clothes, shoes, trips to the water section, brief toilets, struggling into line for the breakfast room, airing rooms, making beds, sweeping floors, emptying collections of spittoons and night chambers, finding pipes and tobacco and small personal possessions, all contribute to confusion. One superintendent has enlarged the water sections in the wards to lessen the congestion at the morning period.

Examples of the morning activities might be read from actual case records.

Mr. T. was seen walking back and forth from his room to the corridor at 7 o'clock when the day nurses came on duty. Four nurses were in the immediate vicinity. It was noticed that Mr. T. had withdrawn to his room and closed the door. When he was followed it appeared that Mr. T. had broken a pane of glass with a hair brush and was walking to and fro in his room cutting his throat with a piece of glass. Patient had not been depressed and had not expressed suicidal ideas or intentions. He had made threats to injure other people but never himself and he had recently been in an exalted mood and believed that he talked with God. There had been an incised wound of the neck five inches in length puncturing into the pharynx and severing the epiglottis. A surgeon was summoned who attended the wound and gave a transfusion.

At 12 o'clock noon the number falls perceptibly as it does at 8 p. m. and remains with a slight rise at 12 an unbroken line until 5.

What happens between 3 and 7 p. m. are probably the arguments engendered from reading, card playing, visitors and lack of activity.

From these preceding and following examples it will be seen that mental and physical states are for the most part responsible for the accidents which occur to the patients. The idea that the afternoon presented some differences by the modifiable factor of fatigue does not especially appear on review of a few cases of afternoon accidents such as—

Miss H., aged 49, a restless patient, was ordered placed in a warm sedative bath. During the bath the patient attempted to hold her head beneath the water. The tub plug was removed and two nurses were about to take patient out when she attempted to get out by herself. She had raised herself part way out when she slipped, striking on her left elbow. The nurses report that this happened so quickly they had no opportunity to prevent the accident. A fracture of the left humerus and two bruises on left elbow were sustained.

Dark Months Bring Increase

The distribution of accidents by months during a year also is graphically represented in Chart F. The dark months, when outdoor activity is lowest, November, February and March, score highest, the number in December, though it is a dark month, probably being modified by the spirit or the fact of the Christmas holiday period. Except for a slight rise in July, usually the first hot month when irritability rises, the curve is

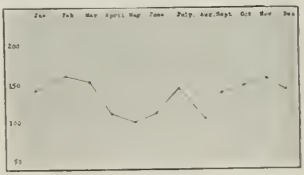


Chart F
Distribution of 1,675 Accidents by Months

CHART G.

A. STATISTICAL
Institution.
Name.
Number.
Sex.
Age.
Hospital Residence.
Mental Diagnosis.
Physique.
Factor Predisposing to Injury.
Result.

B. FORMAL RECORDS.
Date.
Hour of Day.
Ward or Building.
Proportion of Nurses to Patients in Ward or Building.
Routine or Elaborate Report.
Specially Investigated by S. B. I. Agent.
Report to Physician, Name.
Date of Report to Physician.
Interval between Casualty and Report.
Investigation by Physician, Name.
Interval between Report and Investigation.
Casualty Witnessed by (Specify Patient, Nurse, Etc.)
Personal Responsibility Affixed.
Casualty Avoidable with Reasonable Care.
Casualty Avoidable with More or Better Nurses.
Reprimand.
Discharge.
Arrest.
Change of Internal Policy Recommended.
Change of Internal Policy Executed.

C. NATURE AND SEVERITY.
Fracture.
Dislocation.
Gunshot.
Other Severe Injury.
Less Severe Injury.

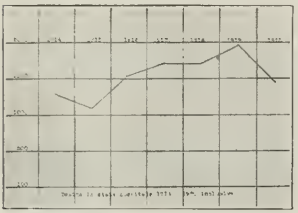
D. MANNER OF INJURY.
Unknown.
Medical Accidents.
Suicidal.
Homicidal.
Self-Mutilation.
Sex-Assault.
Other Motivated Act.
Impulsive Act.
Reaction to Hallucination.
Psychomotor Excitement.
Motor Restlessness.
Paralysis.
Arteriosclerotic Seizure.
Ataxia.
Muscular Weakness.
Sense Defect.
Paretic Seizure.
Epileptic Seizure.
Epileptiform Seizure.
Seizure of Other Nature.
Habitual Dislocation.
Asocial Acts.
Of Another Patient.
Of Attendant.
Scuffle of Patients.
Scuffle with Attendant, Male.
Scuffle with Attendant, Female.
Self Defense.
Retaliation.
Mayhem.
Poisoning.
Occupational.
Machinery.
Farming.
Other.
Unavoidable Natural Causes.

low in summer and distinctly notable in February, March and November.

The analysis of these accidents, assaults and injuries is made each year, and for the purpose of simplifying their analysis a chart was constructed by Dr. E. E. Southard in 1915. This Chart "G" provides for analysis of ten cases, under (a) statistical, (b) formal records, (c) nature and severity, (d) manner of injury, as noted below. At intervals these sheets are bound in book form for reference, and the yearly statistics are compiled from them after consideration is given each case at the department of mental diseases. It is on this statistical evidence that this paper is based.

Deaths

The death rate in state hospitals in Massachusetts has never been devastatingly high, even under epidemic conditions (1908 Danvers dysentery; 1910 Boston State Hospital, paratyphoid fever), until the influenza epidemic pervaded hospitals, as it did in 1918-1919 when they shared the sweeping wildfire of disease and death that the community endured.



13276 13675 14132 14497 14730 14562 14049
Average No. Under Care
Chart H

The per cent of autopsies to deaths in the different hospitals is a varying figure from 0-66 per cent in different years in different hospitals according to the zeal of the chief executive officer and the persuasiveness of the assistants. Perhaps the lack of thrills in postmortem findings affects the zeal and persuasiveness in some cases, possibly the attitude to death changes at a certain period or after certain disappointments. The average total per cent autopsies to death for five years for Massachusetts hospitals was 27 per cent.

Sudden Deaths

The administrative inquiry into sudden, unexpected or violent deaths in Massachusetts state hospitals is done by the commissioner's pathological officers at the time of the occurrence, in this wise: when a patient is dead either by violence (suicide or homicide, accident, burns, poison, etc.,) is found dead in bed, is found dead in a field after elopement or an epileptic convulsion, dies within a year after a fracture of any bone, or within twenty-four hours of arrival in hospital, this is dually reportable to the medical examiner who has jurisdiction over the territory in which the hospital is situated, and to the pathologist who may go or delegate the nearest pathologist to make investigation. By making the inquiry is meant a personal visit to the hospital immediately on receipt of the news of the death. The superintendent usually relates the circumstances and turns the investigator over to the physician in charge of the case and put all facilities at his disposal for inquiry regarding the details of the patient, the record that gives the physical and mental states, nurses who had to do with the patient and any news of the condition of the patient preceding death.

If the story is clear (but not too clear) regarding the status and condition of the patient and develops logically, the inspection of the body follows without comment. The inspection aims to corroborate the physician's statements and to eliminate the possibility of violence; then comes a conference with the medical examiners as to the cause of death, and sectioning the body under his direction if he is not satisfied the patient died of "natural causes," or operating independently if he releases the case and permission is obtained from relatives. The facts gleamed from the visit are embodied in a report to the commissioner of mental diseases so that he may have on record details in case the relatives or others make complaints or arrange notoriety. The superintendent of the hospital also makes an independent investigation and reports with full notes or copies of the previous hospital record to the commissioner. The medical examiner turns in a report to the district attorney. The spirit of publicity to interested persons is thus established and the hospitals have been most cooperative, realizing the importance of conference and the added protection given by the triple inquiry.

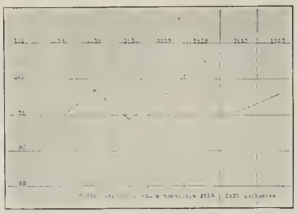


Chart I
Sudden Deaths in State Hospitals, 1914-1920

Chart I gives the graphic rise and fall in sudden deaths for the years 1914-1920 inclusive, and Table I shows the causes of death in 322 patients on whom autopsy was performed.

Heart Lesions and Infections Chief Causes

The near balance of heart lesions and infections will give an arresting pause for thought *re* the mechanism of death in the infections. The cause of death at a given moment in any condition gives pause: Who could estimate the exact time of death in a given case? Who would visualize the mechanism? We may say this person is near death, and that person is profoundly toxic, but what do we see and how does it act? The medulla is probably more influenced than any other shock center by any loss in the balance of CO_2 exchange. Are *all*

TABLE I.—ANALYSIS, AUTOPSIED CASES (SUDDEN DEATHS).

	1913-1914	1914-1915	1915-1916	1916-1917	1917-1918	1918-1919	1919-1920	Total
Heart lesions	4	9	13	13	16	5	8	68
Acute infections	11	13	8	4	9	7	14	66
Foreign bodies in larynx	3	2	7	2	2	..	5	21
Epilepsy	1	6	..	5	4	..	0	16
General paresis	3	1	2	6	1	3	5	21
Homicides	3	3	3	1	2	..	2	14
Suicides	3	3	1	3	3	5	5	23
Tuberculosis	1	2	2	3	2	3	5	18
Fractures	1	3	1	1	2	7*	2	10
Cerebral hemorrhages	..	..	5	..	1	..	2	8
Thrombosis	2	..	..	2	..	..	0	4
After tube feeding	1	..	1	1	..	1	0	4
Burns	1	1	..	..	..	1	1	4
Hemorrhage	1	..	1	..	2	..	0	4
Brain tumor	..	..	2	..	..	2	0	4
Asphyxia	..	1	..	1	..	..	2	4
Katatonic "Hirntod"	..	..	1	1	..	..	0	2
Acute mania	1	..	..	1	..	..	0	2
Collapse after bath	..	1	..	..	..	..	..	1
Salvarsan	..	..	..	..	..	2	0	2
Fall	1	..	..	..	..	..	0	1
Edema brain	1	..	..	..	..	..	0	1
Arteriosclerosis	1	..	..	..	..	1	1	3
Ruptured bladder	..	..	1	..	..	..	0	1
Carcinoma	..	..	1	..	2	1	1	5
Drowned (accident)	..	..	..	1	..	..	0	1
Pernicious anemia	..	..	..	..	1	..	0	1
Acute gastritis	..	..	..	..	1	..	0	1
Edema glottis	..	..	..	..	1	..	0	1
Ruptured spleen	..	..	..	..	1	..	0	1
Ruptured heart	..	..	..	..	1	..	0	1
Alcohol	..	..	..	..	..	1	0	1
Miscellaneous	..	..	..	..	..	1	7	8
Totals	39	45	49	45	51	33	60	322

*Fracture complicated death.

the deaths circulatory in that sense? What is the mechanism in bichloride death, in typhoid fever, in interstitial nephritis, in cardiac lesions? Any general discusson of causation of death is as difficult as a definition of a living thing. Take the ordinary duty of filling out a death certificate armed with the patient's folder and an international classification of the cause of death. If you can narrow down the causes of death to an acute infection and a chronic cardiac lesion, you write them in that order, if there were chronic infection (tuberculosis) and a chronic disease (cancer) no doubt you would write the infection as first cause for purposes of preventive medicine, but there are so few rules that are general that will apply when you are in the process of deciding on a particular and difficult case.

The infections are found to be one of the major visible causes of death, however, in many cases "found dead" in state hospital service, and the infection appears at autopsy to have been operative from three to five days before death, as nearly as one can judge, the patient evidently not registering objectively any complaint, perhaps from faulty subjectivity.

Gross in his admirable book on "The Blood Supply of the Heart" shows that the amount of blood supply to the right heart grows progressively smaller with advancing age, and explains the pneumonia of the aged as due to the failure of the right heart from its progressive anemia. The more the right heart lags, the more the lung tissue becomes vulnerable to terminal infection. The question of unsuspected pneumonia in sudden deaths appear to fall back on the condition of the right coronary.

B 1917.116. A female aged 69, an old case of dementia praecox, vomited her lunch. Did not "feel well." Was about to go to bed when her head fell forward and she was dead—the whole circumstance of a few moment's duration. Autopsy showed arterio-sclerosis and coronary obstruction.

1919.94. A male suffering from dementia praecox and tuberculosis is found dead a few days after complaint of an ulcerated tooth. Autopsy shows pneumonia and tuberculosis.

Foreign bodies in the larynx contribute a few cases annually and happen as many times when the patients eat alone as they do when eating in groups. Whether they mechanically stuff their mouths full and have a sudden dysphagia is a mysterious matter. Certainly, remedial mechanics rarely are effective enough to save life when they have a bolus of food well lodged.

It has been constantly observed that imbeciles, general paralytics, epileptics and seniles should be especially watched to guard against laryngeal occulsion; more latterly dementia praecox patients present such accidents.

B 17.66. A demented dementia praecox male, aged 39, with a positive Wassermann reaction in the blood, was eating his breakfast from a tray when he fell in the process of returning his tray to the serving room. Attendants thought he was having a convulsion, carried him to his room and called a doctor who pronounced patient dead. Autopsy showed mouth, pharynx and glottis completely filled with dry bread.

Difficult to Tell Age of Fractures

The finding of fractures postmortem has caused a great deal of inquiry, more perhaps because of the difficulty of stating the exact age of the fracture. This is probably true of the sane as well as the insane, since the medico-legal hand books say that the first twenty-four hours may show nothing to hemorrhage:

After 24 hours, hemorrhage and edema;
Ligamentous union in three weeks;
Callus formation three weeks to three months;
Immobility and callus three months to one year;
Smoothing of callus edges after a year;
Microscopic evidences may be found on a longitudinal section of the fractured ends;
Fluid blood, first 24 hours;
Blood clot 24-48 hours;
Organization two to four days;
New formed fibrous tissue four days;
New formed osseous tissue 10 days to two weeks.

The normal times set for the proliferation can only apply relatively to the insane, as in other depleting diseases. But the decision must be made as a rule on the spot, since death certificates can hardly wait on the time consuming technique of histological inquiry. The immediate question—has the fracture anything to do with the death?—is often answered negatively in the case of fractured ribs without associated lesion of chest; not so in skull fracture or in pneumonias after rib and femur fracture. And the second question for administrative purposes is, "How old are they?" The next question is, "How received?" and then speculation is at its best.

1. If no bruises are present, no hasty judgment should be made since bruises vary with types of individual skin, whether the skin was protected or not, and fade according to the depth of hemorrhage and the activity of phagocytes.

2. A fat person will resist external chest violence better than a thin one whose bones are more exposed, but may fall more heavily on outstretched arm or on leg and the extremities suffer as much.

3. The general paralytic and the arteriosclerotics and all unsteady on their feet show the greatest number of fractures; occasionally the epileptic has a skull fracture but few considering the number of falls.

4. The pressure of aneurysms on bones and the infiltration of periosteum and bone marrow with new growth are to be remembered also.

5. It is fortunate that the medical examiners respond to calls on patients dying within a year of the receipt of fractures, because while the later than two months' period deaths are probably for remote reasons, it keeps a reassuring atmosphere as well as medical sequelae in mind at the hospital, and precludes outside misunderstandings.

We. 13559. Woman of 48 years dies seven years after a breast operation for carcinoma. She had a leg fracture of a year's standing with no healing, and metastasis to both femurs, other breast and right kidney. An example of a pathological fracture.

1919.80. A restless, deformed, epileptic, imbecile woman of 67 dies within two weeks of hospital admission. Autopsy shows five fractured ribs, bronchopneumonia and cerebral hemorrhage. It was assumed she received the fractures after the cerebral hemorrhage, since it was organized, and the pneumonia was recent and the fractures were not in a healing state.

General paralysis and epilepsy (usually asphyxia after a convulsion in the latter) appear well up in the list of causes of sudden death. In the first we again charge the medulla with being the sensitive spot in uncomplicated deaths from paresis.

Transportation seems to have a very exhausting, untoward effect on aged people during periods of heat and humidity.

1917.37. Was a female patient, aged 77, who was brought in a comfortable automobile over a smooth road for a distance of 25 miles, arriving at 4 p. m. when the temperature was 61 degrees, the humidity 100%. On admission the patient complained of being "tired" but showed nothing of note. She ate no supper but drank a cup of tea about 5 p. m. At 5:35 she was breathing with difficulty and died 10 minutes later. Cause of death, pulmonary thrombosis and myocarditis.

Suicides and Homicides

Suicides and homicides present the most spectacular causes and are the most worrisome of the sudden deaths. Chart J shows a marked rise of suicides in 1918, and can hardly be more than passingly associated with effect

Chart J
Suicides in State Hospitals, 1914-1920

of war as such on these subnormal minds. Perhaps the lowered morale, the substitution of new and untrained helpers eager as they might have been, would have had more points of understanding as a indirect effect of the war.

Chart J

Bo. 20123. A woman of 58, depressed, barricaded the bathroom door, turned on hot water in tub 150°. Burns on legs, perineum, buttocks and arms. Death five weeks later of acute nephritis and chronic mitral endocarditis.

Homicides can be put down almost certainly as an unplanned effect—a reaction to temporary irritation of the snowball type increasing on the attempt of scuffling, retaliation, or transfer of delusions spontaneously.

1916.99. An Italian paretic returns a derogatory remark when the attendant tells him to go to bed, a scuffle ensues, the patient falls to floor and is kicked; dies in half an hour with fracture of skull and several ribs. The attendants are sentenced.

Conclusions

1. The Massachusetts system of reporting accidents occurring in state hospitals to the department of mental diseases removes the air of secrecy which might pertain thereto, and fixes the responsibility in the majority of the instances.

2. The downward curve of the number of accidents 1914-1919 substantiates the hypothesis that they would gradually fall if rigidly reported.

3. The department of mental diseases has by reason of these reports data from which to answer questions as they arise, and can investigate any inequalities of hospital care.

4. Comparing the ratio of ward workers to accidents determines at which ratio a saving in number of accidents ceases.

5. It is a matter of congratulation that so few accidents in proportion to the number of contacts, occur in state hospitals.

6. In 1,863 accidents, 1914-1920, inclusive

9% or 165 were of unknown causation.

6% or 110 were because of occupation.

8% or 147 were unavoidable.

8% or 159 showed involvement of employes.

6% or 115 showed distinct responsibility of employes.

25% or 474 showed involvement of patients.

43% or 818 were due to physical or mental state of the patients.

68% can be directly charged to the patients' diseases.

7. Of these sudden, unexpected or violent deaths, infections and heart lesions lead in numbers.

8. Homicides, about twelve, and eighty suicides have happened in seven years among 13,000-15,000 patients.

FUNCTION OF MEDICAL SOCIAL WORKER

How the medical social worker plays an important part in the hospital in each of its four duties, as he sees them, is the subject of an article by Dr. Franklin R. Nuzum of Santa Barbara, Cal. on "Why Medical Social Service Deserves a Place in Hospital Organization and the Duties of Medical Social Workers Toward Hospital Administration" which appears in a recent issue of the *California State Journal of Medicine*.

The four duties of a hospital, as Dr. Nuzum analyzes them, are: the care of the sick; the advance of medical science; service as the center for activities concerning preventive medicine and community health; and the training of hospital personnel.

In the care of the sick, the medical social service worker is of great aid in obtaining the cooperation of the patient and in carrying out medical orders more effectively, thus aiding convalescence.

"The second duty of the modern hospital," writes Dr. Nuzum, "the advancement of medical science, is likewise interrelated with the functions of the medical social worker. The advancement of medical science depends not alone upon research work in the laboratory but upon critical study of clinical records and case reports. A study of records furnished by the numerous groups of medical social workers throughout this country will afford a great amount of material for the study of diseases from an angle heretofore little considered.

"The time is at hand when the hospital may entrench itself firmly in its community by seizing upon the opportunity for the spread of knowledge concerning public health problems and preventive medicine. There are many ways the hospital can go about this. One agency than can be used with greater effect than all others is the medical social work department."

In the fourth duty of training hospital personnel, Dr. Nuzum believes that the hospital for the most part must supply its own workers and that there is no department better able to train medical social workers than that department itself. The greatest difficulty in this direction has been the backwardness on the part of hospital authorities, often through lack of funds, to develop such a department. In answer to this, it has been shown that such a department actually saves its cost by lessening the number of clinic patient days in the hospital. The supply of trained medical social workers is limited and any hospital maintaining such a department has the responsibility of training social workers, just as it should train administrators, interns and nurses.

As for the duties of medical social workers, Dr. Nuzum points out four: (1) the making of social and economic diagnosis; (2) making accurate records, including treatment and follow-up notes; (3) saving hospital days for the institution; and (4) acquainting the community with the value of its hospital.

HOSPITAL SOCIAL SERVICE

Hospital service has been broadened out considerably during the past years and today embraces considerably more than it did a few years ago. This has been due, not only to discovery of new methods of technique and procedure, but to a much greater study and consideration of the patient as a whole. There is a great deal more involved in the combating of diseases than the cure or relief of symptoms or the scientific care of the patient. The social aspect must be taken into consideration, studied and treated rationally, if we desire that the best results be obtained in the scientific care of the patient. In recent years through the development of the field of hospital social service there has been established a great advantage to medical science and practice in not only assisting in the determining of causation of disease but in the making more permanent cures by correcting of social conditions and follow-up methods through the hospital social service bureau. Investigating authorities declare that social conditions often have a very marked bearing and influence on physical conditions, and here social service comes in as an active agency in counteracting such conditions. This department, which is found in a large number of general hospitals, plays an important role, both in the field of preventive medicine as well as curative, and supplies the link between the hospital and the home or environment as it pertains or is related to the patient. Hospital administration today demands the enlarging of the viewpoint of executive in this work.

"CAROL, BROTHER, CAROL; CHRISTMAS DAY AGAIN"

By DE WITT DURGIN LASH, Chicago, Ill.

THE message brought in song so many times carries with it greater comfort than the spoken message. Because this is so, this article will present an outline of Christmas carols, anthems, solos, cantatas and readings, which may be given with success in the hospital.

In some of the hospitals, choirs and other musical organizations will be secured for this special occasion, while in others there is an organization within the ranks of the attendants and helpers capable of doing splendid work musically. As the carols are the most sought for musical numbers they will be listed first.

"*The Ditson Collection of Ten Traditional Carols for Christmas*" published by Ditson and Company, Boston, is in my judgment, the most desired collection, since it includes many of the best known carols.

"*G. Schirmer's Christmas Carols Annual*," No. 18, Octavo No. 6999 of Eight Old English Carols, arranged by Harvey B. Gaul, are a joy to the music lover. These Old English carols have a rollicking freedom about them that brings much of the Christmas spirit.

Then the "*Old Carols and Traditional Melodies*" arranged by F. Flaxington Harker, published by G. Schirmer, labelled "First Set," are most worthy. Some of the best of the carols are in this collection and most to be desired.

Practically all of the favorite carols are in some of these collections, and almost any one of them will prove most satisfactory.

Choral Numbers Suggested

In mixed choral numbers the list is almost inexhaustible, and the selection a difficult one because of the high standard of them all. The first of these is "*Christmas*" by Harry Rowe Shelley, published by Schirmer, and it is very fine. It can be used by unchanged voices, or women's voices alone if desired.

"*There Were Shepherds*" by C. Vincent, published by Schirmer, is another fine anthem of easy grading It is very singable, easily learned, has a beautiful soprano solo in it, is within easy compass. This number will find a place on many programs.

"*Arise, Shine; for Thy Light is Come*" by George Henry Day, published by Schirmer, for mixed voices of five parts and baritone solo, is a magnificent number where the talent is capable so that it can be well rendered. It is pretentious but beautiful and worshipful.

"*Above the Sleeping World*" by Ira B. Wilson, published by Lorenz Publishing Company, is a fine anthem of medium difficulty, about grade three, and can be readily worked up to a good rendition by the average choir with a good conductor.

"*And There Were Shepherds*" by E. L. Ashford, published by Lorenz, is a novelty in that it has a fine violin obbligato with it, and is very desirable.

"*Christmas Morning*" by Frederick T. Llewellyn, published by Schirmer, Octavo No. 7006, is a fine number for mixed voices (A. Cappella). This number will meet a great need. It is different; still it has merit and value.

"*The Joyful Morn*" by Daniel Protheroe, published by Gamble Hinged Music Co., is a splendid number. Rich in its message, well written as to melody, closing with a rousing chorus makes it worthy.

"*Brightest and Best of the Sons of the Morning*" by C. Whitney Coombs, published by Schirmer, Octavo No. 6590, is a big number with soprano and tenor solos, also violin and harp obbligatos. This number should be on every program where these instruments are to be had for its rendition. It is a great anthem, with unlimited possibilities. The organ and piano parts are rich in the colorful harmonics so rare in a religious writing.

In this list of anthems will be found suitable numbers for almost any grade of singers, but in all cases copies should be secured at once, and work on them done diligently for the best results to be obtained.

Next on the list we will consider the numbers best adapted for women's voices.

"*Oh! to Have Dwelt in Bethlehem*" by F. Leslie Calver, published by Arthur P. Schmidt Co., for three voices is a rare gem. Written in six-eight time with close harmony it makes a direct appeal. It should be universally used.

"*O Child of Mary's Gentle Care*" by R. H. Shelley, published by Schirmer, of three parts is also a fine number, not difficult but singable. It should be easy to get the forces to do this number, where no regular body of singers is organized.

"*The Angel Song*" by E. S. Lorenz, published by Lorenz Co., is a very attractive number for the unaccompanied voices. Written in four-eight time with a slow tempo it is easily handled. Included in the same cover is another fine selection named "*There Were Shepherds*" by Ashford which is also commendable, giving two for the price of one, an item to be considered these days, when music costs much more than it used to.

"*Gloria in Extenso*" by De Costa, published by Lorenz is another splendid anthem for three parts. Forceful in its rhythm, it makes a fine contrast to the lighter

numbers, at the same time carrying its message just the same.

"*Listen*" by J. W. Hughes, published by Lorenz, and "*Underneath the Christmas Starlight*" also a two in one number, are both of them worthy of consideration for the women's voices.

"*God With Us*" a short cantata for women's voices, by Elizabeth Burges Buford, published by Lorenz, meets a need for a short easy cantata for any group of singers wanting something of this kind. It is well written with just enough easy solos to make it attractive; also it is within the scope vocally of the average singer.

Not to be partial, the list for the men's voices includes some beautiful anthems, and quartets.

"*A Christmas Lullaby*" by Ira B. Wilson, published by Lorenz, is a little gem of a number for men's voices. "*The Bethlehem Babe*" by the same composer, also his "*Underneath the Christmas Starlight*" are well written numbers well adapted for the average group of male singers.

"*Christmas Morn*," an anthem in unison by Eleanor Remick Warren, published by Harold Flammer, is just such a number as is many times needed for occasions of this kind. It will fit in where the four parts are not to be had, and where the singers are not good readers.

In these two groups for men and women, an attempt has been made to give something worthy, yet not too difficult, where melody reigns supreme.

In some of our hospitals there will be need for something in the line of short cantatas. To meet such a need, a list of some of the best ones is given.

"*The Angel and the Star*," a two part number for two sopranos, or soprano and mezzo, is a melodic writing, full of harmony and very singable. It is published by Lorenz Company.

"*Sons of Promise*" by Lorenz, published by Lorenz Co., for Sunday school and choir, is a fine number for the Christmas season, with just enough costuming to make it attractive.

"*Yuletide Memories*," a Christmas cantata by Ira B. Wilson, published by Lorenz Company is another splendid number meeting with success. It has fine solo possibilities and strong climaxes.

"*The Star of Bethlehem*," a Christmas cantata for solo, chorus, organ and piano, by F. Flaxington Harker, published by Schirmer, is a short cantata of thirty minutes, and is a great number. Splendidly proportioned, strong climaxes, appealing phrases, it typifies all that is necessary for the success of such a work in a manner most conclusive.

"*The Holy Night*" by John Hyatt Brewer, published by Schirmer, is a remarkable writing. Mr. Brewer has written better than he knew.

Other fine cantatas are "*The Coming of the King*" by Dudley Buck, published by Schirmer; "*The Story of Bethlehem*" by Daniel Protheroe, published by Gamble Hinged Company; "*The Cradle of Bethlehem*" by Irene Berge, published by Schirmer.

CHRISTMAS MORNING AT A BROOKLYN HOSPITAL

By REV. OTTO BRAND, Field Secretary and Chaplain, Methodist Episcopal Hospital, Brooklyn, N. Y.

CHRISTMAS morning has scarcely begun to dawn at the Methodist Episcopal Hospital in Brooklyn when through the long, silent corridors of the great main building, penetrating the quiet of its remotest rooms and even floating out through open doors and windows to adjoining pavilions, there stole, on light melodic wings, the words of that charming Christmas song by Phillips Brooks:

"O little town of Bethlehem,
How still we see thee lie!
Above thy deep and dreamless sleep
The silent stars go by;"

In the hospital chapel some four score nurses and members of the house staff, together with a sprinkling of interested visitors, are gathered to participate in the imposing Christmas Processional which for many years has been a distinctive feature of the hospital's Christmas celebration. It is the blending voices of these, united in holy song, which greeted the rising sun, carrying a message of peace and consolation to the many sufferers beneath the roof.

Continuous with the preliminary devotions the procession begins at the chapel door. With the superintendent and other officials leading, the entire audience marches in double file, singing as they go, to make this annual tour of wards and rooms. Now it is Wesley's world-famous song of the nativity, set to Mendelssohn's majestic tune:

"Hark! the herald angels sing,
Glory to the newborn King;
Peace on earth, and mercy mild:
God and sinner reconciled."

Upstairs, downstairs, to crowded public wards and more secluded private rooms, the procession slowly wends

The Christmas processional at the Methodist Episcopal Hospital,

its way. Through a sinuous passageway to the east wing, up a short flight of stairs, and the children's ward is reached. Here already tiny tots with sleepy eyes behold wonderingly the dazzling tree which during the dark hours of the night has so mysteriously materialized; or, hug to them the pleasing gifts which sly old Santa had deposited upon each white counterpane. Then up another flight to the next floor where many mothers lie, and newborn babes in wee cribs; and other women, too, resting there in blest expectancy. Fraught with deep significance, doubtless, to these women, are the words of the carol which here is sung:

"There's a song in the air!
There's a star in the sky!
There's a mother's deep prayer,
And a baby's low cry!"

Thus the double column of singers moves along on its beautiful mission of gospel cheer. Again and again those old sweet choruses ring out upon the crisp morning air, echoing until the whole group of buildings seem to reverberate with song. One cannot help but note the varying effect of it all upon the minds and hearts of the different patients. Some smile happily and wave their greetings from their beds; others join exultingly in the refrains and responses from the printed service forms with which all have been provided; others again, overcome by swelling emotions, thinking perhaps of loved ones in faraway homes, weep silently or give way to sobbing. Yet is it very plain to see that to all, without exception, this gladly-solemn service has brought a breath of heaven's own refreshing atmosphere; a veritable echo to the angels' story of an old day, "On earth peace, good will toward men." Always singing, the procession makes its way back to the chapel and here the closing chorus is sung:

During the war a whole pavilion was set aside for the use of Navy patients. This shows the boys in one of the two wards just before they sat down at one big table to enjoy an old-fashioned Christmas dinner.

"Joy to the world! the Lord is come;
Let earth receive her King;
Let every heart prepare him room,
And heaven and nature sing."

Then, with brief prayer and the benediction, the service comes to an end. To an end? No, hardly. Who but He who can read the secrets of the mind can tell what uplifting thoughts were born, what heavenward impulses stirred, what famished hopes and languishing resolves revived by that sweet, traveling message of gospel song that Christmas morning. After all, how few things in this world have the leveling power of sickness and suffering. Pain knows no creed, no color, no nationality, no social caste. The fellowship of pain begets a brotherhood of sympathy which is but a step removed from religion's highest ideals; suffering and affliction bind together the hearts of rich and poor, black and white in total disregard for differences in religious persuasion. Perhaps in no other place, at no other time and under no other circumstances is the essential unity of genuine religious faith so manifest as in its tender application to the needs of the suffering sick within hospital walls. Important issues though they be in other spheres, in the hospital the calm, loving, human ministration to human need and the common hope to regain health, banish the antagonisms of creed and race. Here man learns to know his fellowman as brother. At least it would seem that such thoughts as these must have been begotten in the hearts of those sick men and women as that early morning procession swept by with its soul-stirring message of the kingly, brotherly Christ who "rules the world with truth and grace and makes the nations prove the glories of his righteousness and wonders of His love."

TO HEAD REID MEMORIAL HOSPITAL

Miss Mary Elizabeth Springmyer, R.N., for eight years connected with the surgical department of Reid Memorial Hospital, Richmond, Ind., has been named superintendent of that institution. She succeeds Miss Clara B. Pound, who has directed the hospital for the past five years and who left the middle of September to assume the duties of superintendent at the Lafayette Home Hospital at Lafayette. Miss Springmyer, before her association with Reid Memorial Hospital, was connected with a Cincinnati institution.

Brooklyn, is very impressive in its nature

HOLIDAY FAVORS FOR PATIENTS

By JANET S. WARD, Dietitian, Hahnemann Hospital, Philadelphia, Pa.

CHRISTMAS approaches, and the question, "Shall I get home for Christmas?" is asked of the doctor each day, sometimes to be answered in the negative. Depression follows, as memories center around family gatherings on that day of sacred association, but even to the private room permeates some inkling of the preparations being made by officers, nurses, and dietitians to brighten and cheer the guests who have to remain during the time they so intensely desire to be at home.

When the breakfast is carried in Christmas morning, a jolly looking Father Christmas beams from a conspicuous part of the specially well appointed tray, while a greeting card conveys good wishes. This beautific reproduction of the legendary dispenser of good things to all good people (especially children) is a neat little lolly-pop dressed up in green and red crepe paper; the face covered with pale pink paper and decorated with the orthodox white beard and hair, (materials for which have been borrowed from the operating-room supply closet) has been painted to make him as "Santa Clausy" looking as possible. The lolly stick has been sharpened by the pencil sharpener, so that it easily sticks into a rosy cheeked apple, while the ample skirts spread over it, giving the whole a realistic appearance.

For the last few years each patient in our hospital, ward and private, has had one of these on his Christmas breakfast tray, and we find they are as much appreciated by the grown-ups as by the children, perhaps more so. It may seem a puerile gift to give to adults, but it is the personal touch—something seasonable which has been made especially for them—that appeals, and even the ludicrous appearance of the little fellow helps to chase away the gloom that is likely to cloud the morning.

On the dinner tray some such decoration as a red crepe paper flower containing in its heart a tiny paper cup filled with raisins and candies adds a festive touch to the other attractive items of the Christmas menu.

Last Christmas we added a unique supper favor in the form of an oblong cookie resembling a small pictorial postal card. The cookie is coated with white icing, a stamp seal is placed on the upper right corner, a colored spray of leaf and flower is piped on top left corner, a line is piped down the center with a fine-writing icing tube; on the right side the patient's name and room number are piped, while on the left is a Christmas greeting.

Of course, all these favors mean a great deal of additional work, but we find that nurses willingly give evening hours to make the articles which will add to the happiness of the patients who are compelled to spend the home-gathering times in the hospital.

Not only Christmas but every holiday, we mark, for the private patients, at least, with some little attention which helps to divert their thoughts into another channel. Last New Year's day on each private breakfast tray was a small card bearing the following lines which, though not poetry, seemed appropriate:

Just a little jingle.
Along with breakfast trays,
To wish that health, peace, love may jingle
Through all the New Year Days!

All Holidays Remembered

Valentine, St. Patrick's, Easter, Decoration, Independence and Armistice Days, as well as Washington and Lincoln birthdays, are all appropriately marked; and of course Thanksgiving Day, especially so! Occasionally the favor is not so appropriate as it is planned to be, as was the case last Independence Day. The temperature on July 4 in Philadelphia is usually around the nineties, so we thought the idea of presenting each patient with a patriotic looking fan on the breakfast tray quite brilliant. An enjoyable evening was spent making over 100 red, white, and blue crepe paper fans, and we pictured our guests blessing us as they used them all next day. The weather man is as fickle as the proverbial woman, and the morning called for extra blankets instead of fans, though they got the fans too!

We have many proofs that some, at least, appreciate the attention, and realize the labor which even the simplest gift for each one entails; also, that some of the sick are helped toward recovery by having the dark days of trouble brightened even a little.

For those who give time for which they are not paid it is good; for those who give it free'y, in love, the kingdom of heaven is brought a little nearer, here and now.

Holidays in the hospital are brightened by giving some little personal touch to the patients' trays. Here are some holiday favors made at Hahnemann Hospital, Philadelphia: (from left to right) Christmas candy and nut basket; Hallowe'en witch; Fourth of July fan; Father Christmas; Thanksgiving nut and candy basket.

"SHE'S THE KIND THAT DOES THINGS!"

By ELIZABETH COLE, National Tuberculosis Association, New York, N. Y.

"MY WORD, but this is a heavenly day!" exclaimed Mary King as she rattled along the highway in her little old Ford. And to give emphasis to her joy over the bright warm sunshine, she fed more gas to the engine. The car seemed to exclaim its delight by jumping and bumping ecstatically.

"No sense in taking a spill, old dear," said her companion, Isabel Gray. "You know this dashing steed might get light-headed through your enthusiasm."

"Oh, don't you worry. We'll keep on the road," replied Mary. "But I must say I feel like jumping up in the air. Don't *you* bother to though, Miss Lizzie," she said addressing and patting the steering gear. "Isn't it just great to be living on a day like this? And aren't you glad you're healthly and at the seashore and able to see and feel this gorgeous air?"

"It certainly is one of the summer's very best," answered her friend. "I'm getting ravenous, too, aren't you? Let's go bathing just as soon as we get home. Why what's up?" she added as Mary began to slow down.

"Look at that boy, Isabel," Mary cried, "Look at him —he's walking just like my Bobby."

"He is, isn't he? Why, Mary, he's got on a uniform. He must be a returned soldier. Heavens, but he looks tired."

"Oh Isabel, supposing that were my little Bobby walking along the road, alone like that. Let's give him a lift."

Isabel realized the thoughts that were going on inside her friend's head. "Poor kid!" was all she said. Mary's little six-year-old son had had tuberculosis of the hip and although he was well now he still walked and ran with a limp.

They came up to the lame, weary-looking figure and stopped the car.

"Want a lift?" called Mary in her friendly pleasant voice. "Jump aboard."

The boy turned and looked gratefully at the two in the Ford. How many, many cars had gone right by him that day! He wiped his hot damp forehead with his hand and nodded "Yes."

"Just push aside some of the potatoes and mail and green corn," said Mary as she cleared a place for him on the back seat. "We've been doing the daily marketing," she explained as he pulled himself up into the car. They noticed it was not without an effort.

"Rather tired, aren't you?" asked Isabel, "Have you come far?"

The boy sank back on the seat and seemed almost too exhausted to answer. He nodded and said "New York. Walked most of the way. Got a few lifts. Thanks."

"The poor thing!" said Mary in a low voice. "Do you know I'd like to take him home with us. Where's your home?" She turned to ask.

"Haven't any, ma'am. No folks."

"Where are you going?" asked Isabel.

"Nowhere special. Couldn't get work in the city and the doc thought I'd do better in the country anyhow," he replied.

"Oh Isabel, I've *got* to take him home," emphatically said Mary in almost a whisper. "Just think if it were Bobby twenty years old and no home. Why he walks just like him and I know he's had the same trouble."

"Well, do as you like of course, Mary, but he may get sick on your hands."

"He needs somebody to help him." And Mary looked with her big pathetic eyes at the drooped figure. Isabel thought as she regarded her friend that she was just like the little girl, Mary, who always used to bring home stray cats and dogs and little wounded birds to mother. Everbody had always loved Mary even though they did make a bit of fuss at the inconveniences caused by her big-heartedness.

"O I daresay Ted will think I'm a silly—but I'm used to that—and so's he, for that matter" she added, laughing.

Is the world topsy turvey when children in zero weather stand on their heads, unclothed and happy? (Seaside Hospital, Niantic, Conn.)

"Maybe we can get him a job mowing lawns or driving a car or something," suggested Isabel.

"Want to come on home with us." asked Mary, turning and raising her voice, "What's your name?"

"Tony DeMatteo. Sure. Thanks," were the replies, given to be sure in the wrong order.

The Ford brought them bumpily home over the country lane that led to their cottage on the Sound. Tony was given a couch on the screened-in porch and promptly went into a sound sleep.

"Who's your friend?" Mary was asked by her husband, son Bobby, and all his playmates and their neighbors. She had to endure uplifted eyebrows over the slight information she could offer regarding him. "Hope he won't take the family silver," humphed her good-natured husband, "that's all I ask."

"Where'll he sleep, mother?" "What'll you do if he never wakes up?" "How do you know but what he's a thief, faking this lameness?" "Too bad you couldn't have picked up somebody good-looking!" were some of the remarks hurled pleasantly at Good Samaritan Mary.

And they continued to be hurled, for Tony continued to sleep. It was late in the evening when he awoke and the family was reconciled to his remaining on the couch for the night. He ate ravenously when Mary brought him a tray full of sandwiches and milk. He also began to talk about himself and confirmed Mary's surmise regarding his lameness. He had had tuberculosis of the hip joint when he was a little boy. He was supposed to have been cured and would undoubtedly have remained so had the exposures in France not brought on the old trouble. He told of enlisting at sixteen, of going across with one of our first troops as a private supposed to be twenty years old, of being gassed, then lost and reported missing. He finally returned to New York to find that a brother, his only relative, had moved to Boston—his address he knew not but he had determined to find him. When asked why he did not go to the Red Cross, the Veterans' Bureau, or to a tuberculosis clinic or hospital, he replied that he thought they had all gone out of existence since the war was so long over!

Tony came for a few hours' rest, but he remained for a week at Kings. Poor Mary! She was the only one who had real faith in him and insisted that he be allowed to rest on the sunshiny porch. Her husband skeptically called him "our hero" and could not believe his overseas story. He fumed a bit but consented to be his host on condition that they have a doctor's advice. Dr. Thompson, the village physician, therefore eventually made him a professional call much against Mary's wishes.

"He's not a specialist, Ted," she insisted, "Why waste time on hearing what a country doctor has to say."

"I suppose you want to get an expert up from New York. Sure, spend a few hundred on the boy and go without food?" was her husband's adjoinder.

"No, not that, darling," said Mary. "But he ought to have a tuberculosis specialist. I'm going to look into this thing and work it out right."

"All right, you great-hearted, impractical baby. But I'll wash my hands of the whole matter if you'll just have Dr. Thompson come over."

Dr. Thompson sure enough after talking with Tony for a few minutes reported in a loud aside to Ted. "Nothing the matter—just wants resting up."

But Mary was not satisfied. She did not know about the Veterans' Bureau but she did know of a tuberculosis clinic in a nearby city. The next day she found at this clinic that an orthopedist could be consulted, and for nothing. She took Tony to him at once for a careful examination. The result was that he was placed in a hospital where heliotherapy, the sun cure, was practiced. He was allowed to remain there until sunshine treatment had healed the tuberculosis that had become active in his hip. Moreover, he was cured absolutely free of charge.

When his story was told the genial doctor by Mary he smiled and said, "I suppose everybody tried to convince you that he was faking?"

"Yes, they did," replied Mary, "and I almost believed it myself."

"Well," said the doctor, "it's a strange thing but that is one of the characteristics of bone tuberculosis. The patient gives the effect of a faker and oftentimes even the family and his dearest friends are inclined to believe there is nothing the matter."

"Thank goodness, I insisted," said Mary. And then she added, "You know, doctor, my little boy had tuberculosis of the hip when he was only four years old and although I know he is really cured I just couldn't help but feel that maybe some day he might have a reactivation of the disease and there might not be anybody to help him."

"Did he have heliotherapy treatments, too?" he asked.

"Yes," she replied, "On our own porch. He was so young at the time the doctors said we really could feel that they had put over a successful cure. But we spent loads of money on him and I certainly was worried where the money would come from for Tony."

"You might well worry, my dear Mrs. King," said the doctor, "if it were not for Christmas Seals. Don't you realize that the funds raised every year by the sale of these holiday stickers is used for just such cases as Tony's? They also have helped to build sanatoriums, hospitals and open air schools,—and they even help to pay my salary!" Then he added chuckingly, "I could stand for bigger sales too!"

"Christmas Seals?" cried Mary, "Why to be sure—I've always bought them but, heavens, I had no idea they did all that good. I'm certainly going to make everybody I know buy bunches of them this year, doctor. I'll help get your salary raised!" And as Mary went gaily and determinedly down the walk, the doctor thought to himself "Yes, she will. She's the kind that does things."

Heliotherapy is a comparatively new treatment for tuberculosis in this country. It was practiced, however, as far back as the fifth century, B. C. by the Greek, Herodotus, who realized the beneficial effect of the sun. Dr. A. Rollier in 1903 established in Leysin, Switzerland, the most famous sanatorium of its kind for the treatment of bone and joint tuberculosis by means of solar radiation. His buildings now house over 1,000 patients and his cures have been remarkable. In this country the first scientific and systematic experiment was tried about seven years ago by Dr. John H. Pryor who introduced this "sun bathing" treatment in an extensive and complete manner at the J. N. Adam Memorial Hospital at Perrysburg, N. Y.

Other similar institutions have sprung up throughout the country but funds are low and it is not always as possible to find a place near at hand where free treatment may be received as it was in the case of Tony.

Yet Tony is only one of hundreds who owe their treatment and cure to the Christmas Seals. They are sold in December by the National Tuberculosis Association and their 1,200 affiliated agencies. The amount of support given to the campaign at this time will determine how far they may carry on their work of stamping out tuberculosis in 1923.

AMENITIES OF LIBRARY WORK IN A HOSPITAL FOR THE TUBERCULOUS

By LOUISE SWEET, Librarian, U. S. Public Health Service Hospital No. 41, New Haven, Conn.

THE amenities of library work in a tuberculosis hospital—does it sound too flagrantly cheerful?

Not when the hospital contains 500 ex-service men, most of them in that hopeful and exuberant decade, the twenties. Barring a few very sick men, one finds the same interests, the same humor, the same hopes as among a like number of able-bodied men outside. There is very definitely no pervading spirit of melancholy, and the fact that many of the men look perfectly well helps the illusion that it is a normal community, that perhaps the men are only being "hired by the government to test the beds in its various hospitals," as one humorist among them put it.

An occasional hospital visitor somewhat naively asks, "How are the boys?" and the one questioned searches in vain for a sufficiently accurate blanket answer. There is much the same difficulty in answering the query, "What do the boys read?" Western and detective stories—yes—but that only superficially answers the question. That is the surface want of many of them, but there is scarcely a man who has not other book cravings, sometimes unformulated even to himself. To the librarian who is daily accosted with them, there is an almost terrifying consciousness of human cerebration in contemplating the book wants of 500 men. What a myriad of individual bents and ambitions underly them? What a glimpse into the motivations of 500 human entitles!

The library at U. S. Public Health Service Hospital No. 41 functioning

"How like the stars are these white, nameless faces,
These far, innumerable burning coals,
This pale procession out of stellar spaces,
The Milky Way of souls;
Each in its own bright nebulae enfurled,
Each face, dear God, a world."

For a concrete realization of this, one has only to look through a month's miscellaneous requests: Someone wanted Fiske's *Beginnings of New England* to start a course of reading in American history; Headlam's *France* filled the demand for a "popular history," to satisfy an interest aroused by reading French historical novels; Bayley's *Complete Photographer* so completely filled the bill for a patient who is a camera enthusiast that now he wants to buy the book; Creighton's *Age of Elizabeth* met the want of another patient whose temporary hobby was English history, especially the Tudor period; Krows' *Play Production* supplied another patient whose hope it is to get into the theatrical business when he leaves the hospital; the demand for Parmelee's *Criminology* was induced by the omnivorous reading of detective stories; Cross's *The Short Story* and Sargent's *Technique of the Photoplay* were for patients with literary aspirations; Brown's *Poultry Husbandry* was for serious study by a prospective poultryman; Webster's *Great Speeches* supplied a demand for Webster's reply to Haines; Lutz's *Practical Art Anatomy*, Smith's *Outdoor Sketching* and MacWhirter's *Sketch Book* were used by patients with art inclinations; Wilcox's *Poems of Passion* and Guest's poetry were for a bedridden man whose reading interests for the time centered only in poetry; Spencer's *Data of Ethics* was the demand of an orderly whose earlier requests had been for Schopenhauer's essays and DeQuincey's *Confessions of an Opium Eater;* Darwin and Voltaire were wanted by a patient whose range of reading runs from Sax Rohmer to William Shakespeare; Payne's *Age of Reason* and Ingersoll's essays are recurring requests from some patients less inclined to accept docilely inherited religious traditions; Copplestone's *Silent Watchers* filled a doctor's call for Admiral Beatty's story of the North Sea fight; Ketchum's *Structural Engineers' Handbook*, Leutweler's *Machine Design*, Fiebeger's *Civil Engineering*, Scovell's *Cost Accounting* and Friedel's *Training for Librarianship* all indicate a looking forward to future careers.

There is nothing too impossible to be asked for. It is rather piquing to one's curiosity when a Filipino patient with a typically enigmatic, Japanese cast of countenance asks with great gravity for a new book "The Nervous Housewife." Another patient, contemplating going into that business, wants a book on the designing of women's gowns; another is interested in raising game cocks, though with some doubt as to the legality of their use; another is a professional boxer and the only book of interest to him is one on his specialty.

Tuberculosis Books Read Greedily

It is part of the psychology of a tuberculosis hospital that a book on "T B" is always greeted with mirth. "Here's something for you, Mac," says one man to his neighbor in the tone of one perpetrating a joke, when a book on tuberculosis is observed on the bookcart. "Mac," laughs appreciatively but before the cart moves on, either one or the other is apt to decide he will take the book and give it "the once over." It is surprising how many stories bring a "T B" character into the plot; such are quickly discovered by the patients and those books' circulation is thereby stimulated. That has been the case with Harben's *Inner Law*, Grey's *Heritage of the Desert* and Service's *Rhymes of a Rolling Stone* which includes a poem on "The Lunger."

Sometimes there are glimpses of suppressed hopes and ambitions, as when one bed patient noticed Andrew's *Man Power* on the cart, but when his taking it was suggested, he said, "I don't dare. That used to be my kind of business."

Forgetful of pain and surroundings

Looking over the book cart's wares

One morning a bed patient who had heretofore done only spasmodic reading of O. Henry and the like, a silent boy with a pathetically tense expression, made the rather abrupt inquiry, "I suppose the city library has about every book there is?" After some gentle drawing out for further specifications, he burst out with an intensity that bespoke hours of ennui endured, "I've got to get interested in something or I'll go crazy! Do you think the library has anything on ammonia refrigeration?" There was real animation in his face and voice the day after he got his book on ammonia refrigeration, as he expatiated on its various points.

Much Effort for Self-Improvement

Recently, on his first interview with the librarian, a youthful patient in the receiving ward indicated a desire to pursue a "month's reading course in something worth while." As offering possible suggestions, he was shown a number of the reading lists issued by the United States bureau of education. The only ones omitted as not exactly pertinent were the reading course for girls and that for parents. He had not gone far in his perusal of the others before he came upon a complete list of the Bureau's reading courses and immediately called for the one for parents. Met with a somewhat astonished inquiry as to one so young being in the category of parents, he owned up proudly to a six-year old son. Now he is waiting for Oppenheim's *Development of the Child*, and filling in the interim with Fiske's *Beginnings of New England*, American history being the subject next in interest to parenthood with him.

There is plenty of humor, accidental and intentional, in the day's round. One man, having requested Shakespeare's "poems," came back much disappointed with the copy of Shakespeare's sonnets he had borrowed. "I can't find the one I'm looking for," he explained. "It's one I heard read and the party said it was from Shakespeare." Urged to be more specific, he confided that the title was *"The Cremation of Sam McGrew."* Another man handed back rather dejectedly a detective story he had read and complained, but with a glint of humor in his eye, that he didn't care much for it. "It's only a robbery," said he, "and nothing less than a murder satisfies me any more."

A patient in the receiving ward applied one morning for French and Italian books; on the next trip, Russian and Chinese, were demanded. The man's ambition, seemingly, was to become a linguist and he spent his days reading aloud from his foreign books. "I get Russian books today, speak it tomorrow," he imparted to another patient. "I get Chinese the next day, speak it the day after that"; but his plans were thwarted before their realization by his transfer to a psychiatric hospital.

It is interesting to observe the inclination of many of the men toward book buying. Sometimes they indulge in rather reckless expenditure. One patient has recently bought a much illustrated war history costing $30; another, a very fine edition of Webster's dictionary at the same price; someone else has ordered Simond's *History of the World War*, another expensive work. One man buys periodically volumes in the Lippincott Farm Manual series, with the intention of ultimately owning the set; another in his effort toward self-improvement bought within a month a book on business letter writing, one on social letters and another on etiquette. One man has brought his set of the Harvard Classics to the hospital with him.

Men Interested in Investments

That there is considerable thought among disabled ex-service men on how best to invest their compensation is evidenced by repeated calls for books on stocks and bonds, building and loan associations, and books of general advice on saving money. A bit of overhead conversation on the subject is apropos: One man of a more radical turn made the statement: "No one ever got rich through saving more than the first or second thousand." From the next room came a hoarse voice in unexpected rejoinder, "I disagree with that. I've saved five thousand already in only a few years." Time prevented hearing the outcome of the ensuing argument between radical and conservative.

Unfortunately there is no guage to measure accurately the efficacy of a book. Its value is evanescent, as are all spiritual values, fluctuating with time, place and mood of the man, and in a tuberculosis hospital the latter is closely involved with the weather. It is a live book that can break through the apathy that enshrouds the bed patients on a rainy day. But that books do take the men out of themselves, there is daily testimony.

"It's time to eat," said a patient one night as he hurried his selection from the bookcart, "but I'd rather have the books than the supper."

"That's the best book in the library," commented another man to his neighbor in the next bed, as he finished *The Americanization of Edward Bok;* he had plainly had a respite from self and "T B" while absorbed in Bok's story.

"Books," exclaimed one man to another, apropos of the bookcart's arrival, "They're all that hold reason together."

By such spontaneous evidence is the postulate confirmed that

> "There is no frigate like a book
> To bear us leagues away,
> Nor any courser like a page
> Of prancing poetry!"

WHAT KING EDWARD'S FUND DOES FOR LONDON

By FREDERICK G. GREENE, General Secretary, United Hospital Fund, New York, N. Y.

KING Edward's Fund has just completed twenty-five years during which it has received large sums for the London hospitals and has been accorded a position of great influence in shaping hospital development and policies. Its total receipts during this period, not including 1922, aggregate £6,093,273, about $29,500,000. The cost of administration was only 2½ per cent of the receipts in 1921, which were £274,779, equal to about $1,332,668.

Of the total receipts £107,206 was income from investments. The fund receives many legacies and has investments amounting to £2,271,397, ($11,016,275.00) of which £1,464,599 must be retained as capital, the income only being used, and £809,797 is available for general purposes. This large endowment is found not to lessen current contributions. It is considered important that the fund should have a strong financial basis so as to maintain a constantly increasing distribution and exert a steadying influence in hospital finance.

Has Public Approval

In 1920 King Edward's Fund was entrusted with the distribution to London hospitals of £250,000 for the British Red Cross Society, and also made an emergency distribution of £250,000 out of its own reserves.

In 1921 in view of the critical hospital situation, the Minister of Health set up the Voluntary Hospitals Commission, and King Edward's Fund was constituted the Voluntary Hospitals Committee for the London area. During the past year the King's Fund at the desire of all concerned, has taken a leading part, first, in a successful United Appeal for an emergency fund of £500,000 to match an equal government appropriation; and, second, in devising methods for securing regular collections and payments from the hospital using class. It should be understood, that contrary to the New York custom, private patients do not go to the voluntary London hospitals, which thus lose a large source of income. Moreover, the ward beds have all been practically free, only voluntary gifts being accepted. Steps are now being taken whereby those who use the hospitals and can afford to pay or to make provision in advance by periodic contributions, shall do so.

Organization of the Fund

The work of King Edward's Fund is carried on under the presidency of the Prince of Wales by a general council of seventy appointed annually by the president and working through five standing committees, as follows:

1. Management committee, which consists of its own chairman and vice chairman, and the chairman of the four other standing committees, and deals with the general administration of the King's Fund and with questions of policy not referred to any other committee.
2. Finance committee, which deals with investments.
3. Distribution committee, which deals with applications for grants from hospitals, with the conditions to be attached to individual grants and with schemes of extension or improvement put forward by hospitals.
4. Hospital economy committee, which deals with questions of hospital economy in the widest sense of the word, including accounts, statistics and the proposals for coordination and reduction of expenditure.
5. Revenue committee, which deals with questions relating to the raising of money for the King's Fund and the hospitals, including proposals for increasing income from patients.

There are forty medical and forty lay visitors who inspect and report each year upon every institution aided.

The hospitals, as such, have no membership or representation in the King's Fund.

The hospitals make applications to the Fund for grants in March and the awards are made in December, upon the recommendations of the distributing committee after careful consideration of the work and needs of each institution. Certain general principles are followed in the allotment, but special needs and opportunities are also recognized by special grants such as "to reduce debt," "for rebuilding or extension in accordance with a scheme approved by the Fund," "for nurses' quarters," "for improved kitchen," "to extend out-patient department," etc.

The aim is to give most help to those hospitals that most need and deserve it, while at the same time encouraging them to assist themselves by efficiency and economy of management. The distributing committee makes note of hospitals where the cost per day is high in comparison with other similar hospitals or where there has been a disproportionate rise without adequate reason.

Hospital Development Wisely Encouraged

The King's Fund now aids 110 London hospitals to the extent of about one-tenth of their total annual expenditure which is about $12,000,000. The hospitals are expected to make all due effort to secure gifts from their natural constituency, and to maintain a sound financial position.

New hospital plans and extensions are not encouraged except as they can be justified from the standpoint of geographical distributions, comparative urgency and financial feasibility. Where better results would be gained by the consolidation of small and weak institutions, this course is made a condition of further aid.

The Fund's grants fluctuate with the varying fortunes of the different hospitals, and thus have an important function, partly as an equalizing factor, and partly as an encouragement to special efforts.

Uniform Audited Accounts Required

All hospitals aided are required to publish their finances, duly audited, in accordance with the uniform system of hospital accounts. Economy is encouraged by the printing of an annual statistical report which facilitates comparison as to various items of cost and operation in different hospitals.

King Edward's Fund cooperates in the matter of accounts with the two older London hospital funds, namely —the Metropolitan Hospital Sunday Fund which received collections from over 2,000 religious bodies, and from the Hospital Saturday Fund which collects from wage earners on a system resembling hospital insurance. In 1921 the Hospital Sunday Fund received £108,880 of which about £40,000 was income from investments. The receipts of the Hospital Saturday Fund is about £60,000 yearly.

Special investigations are made from time to time by King Edward's Fund, and reports are published on questions affecting hospitals, such as: fire precautions, expenses of charity entertainments, cooperative contracts, the out-patient question, the revised uniform system of hospital accounts, pensions for hospital officers, policy for the preservation of the voluntary system of hospital management and control, hospitals and medical schools.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

CHRISTMAS CHEER AMONG STUDENT NURSES

HOW student nurses may unite to bring about a jolly Christmas season to the patients and to themselves is best told through specific instances of such achievements. Nurses in training at several hospitals, where Christmas of 1921 was a merry occasion, have written THE MODERN HOSPITAL an account of their festivities. Other schools may find in these suggestions an inspiration.

An account of a most successful party given by the senior class in the training school of Huron Road Hospital, formerly the Cleveland Homeopathic Hospital, is given by Miss Luie Oakes Smith of the class of '23.

Christmas Party at Huron Road

All of the week before Christmas the senior class of Huron Road Hospital was holding meetings wrapt about with solemn mystery, for upon the senior class each year devolves the happy privilege of planning the Christmas Eve party for the faculty and students of the training school.

Each class in turn wishes to make its particular party the best ever, and truly each one seems so, as it comes along. So this year they were planning for this "best-ever" party, and I will tell the result of their planning and see if you do not agree with me that it was a truly good-time Christmas.

Our superintendent always directs the decorating of the place before Christmas and it is tastefully and beautifully done. The main hallway of the hospital is decorated with Christmas greens so that when you come in from the outside, the very spirit of Christmas seems to greet you in the fragrance of evergreen and holly.

The nurse's home is also decorated in the main hallway and in the living room with Christmas greens and bells. The living room is situated at the end of the building and at the side of the hall. At the end of this long hall the seniors placed their tree, bright with all its gay array of Christmas decorations. They asked each student in the school to contribute one gift, not to exceed twenty-five cents in cost, which was to be suitably wrapped and ready to be placed on the tree. Not knowing what was in the packages or who had given them, a committee of girls marked these packages each with the name of a student in the school. These gifts, of course, were of various kinds; some of them were funny and many of them were useful. Also, there were many individual gifts among the students and members of the faculty which were placed on the tree.

Christmas eve after we all had assembled and had finished admiring the trees and the decorations, Santa Claus distributed our gifts. We had all been wondering since coming down stairs as to the meaning of a collection of many cords which were attached to cards and ribbons and tied to the various branches of the tree. After we had been given our other gifts, Santa informed us that the gifts he had brought us were at the other end of the lines. Of course, we all made an excited scramble to find our cards and then we started winding up those cards to get our gifts. It may sound easy, but I can assure you it was not, for those lines crossed and recrossed, wound in and out among furniture, went upstairs, and down through the dispensary, into the kitchen and other dark corners of the basement. One of the students followed her line upstairs and down and through the mysterious depths of the basement only to be lead upstairs again and find her gift neatly tucked beneath a branch of the Christmas tree.

These gifts when opened were received with shouts of merriment, for each one was a good natured take-off on some particular characteristic of the recipient. There was a feather duster for the girl who was noted for energetically cleaning things up wherever she was on the wards; and there was a toy telephone for one of the interns, who was very much in love and made much use of the long distance telephone.

When Santa had come to the end of his jolly pack and the laughter had subsided we enjoyed a dance to the music of our new phonograph, nibbling the while of the generous supply of candy and fruit that the staff contributed to the Christmas frolic. Then we gathered around the piano in the living room and joined in singing Christmas carols.

Christmas morning we dressed a little earlier than usual and assembled on the upper floor of the hospital; with our superintendent leading we went through the hospital singing carols on each of the floors; to the kitchen where we sang to the maids; and thence to our breakfast and on duty.

Patients' trays at noon were decorated with a bit of holly and cheery Christmas card, and I am sure that all of us tried particularly, on this, Christ's birthday, to help our patients forget their discomforts and pain and feel a little of the season's joy.

Three hundred nurses at the Toronto General Hospital, Toronto, Canada, had a happy time last Christmas by bringing joy to many others. Of some of their activities, Miss Evelyn K. Cameron writes as follows:

Christmas in a Canadian Hospital

You say "How can a home-like Christmas atmosphere prevail in a school of 300 nurses?" I shall tell you how

it did at the General Hospital of Toronto last year.

About the middle of December huge red stockings were made and distributed among the nurses to be filled for the hospital social service tree, with the stipulation that they should at least contain one useful gift. We thoroughly enjoyed the shopping expeditions necessary for a real Christmas stocking. Two days before Christmas the tree was held in the Outdoor Department. The previous day the stockings had been brought in and the tree decorated. About two o'clock the children began to arrive, eager with anticipation.

First there was a "Punch and Judy" show which was very popular, but not so important as what followed. With the sound of sleigh bells in the distance, the children became very much excited, and when Santa Claus finally appeared, it was impossible to keep them in their seats. The nurses who were able to be present assisted in giving out the stockings and later served refreshments to the children and their mothers.

cause to be happy smiled cheerfully and wished everyone a Merry Christmas. Children, who were patients on the wards, each found a bulging stocking tied to the head of his bed, the night nurse being the unexpected Santa Claus. It was touching to see their radiant faces as they explored the contents.

Several of the wards had Christmas trees, and the nurse in charge of the obstetrical floor carried out a nice idea of having a miniature Christmas tree for the babies. When the nurses came on duty Christmas morning a baby was brought out in his cot to represent the nursery. Some of the officers of the school were present; a portable organ had been brought up and Christmas carols were sung. Afterwards everyone received a gift from the tree; nurses, pantry maids, elevator boy, no one was forgotten and, although this little event concerned only a very small part of the hospital, it was symbolic of the spirit of good will everywhere present.

During the forenoon the choir of one of the large

Christmas preparations are elaborate in the nurses' quarters of St. Luke's Hospital, Cleveland

The day before Christmas all spare time was spent in decorating the wards and preparing for the old-fashioned party in the residence on Christmas eve. The nurses came to the party in quaint old costumes and brought gifts—small absurd gifts. Then followed old fashioned games, dancing and general merry-making. Later around a heart-warming grate fire, old songs were sung and stories told. We were so busy being happy that we forgot to be lonesome and the party was a complete success.

All week mysterious parcels had been delivered at the residence office, and as a special concession for Christmas sent to our rooms. Our class had not opened a single package, but when an alarm clock rang at five-thirty Christmas morning, the corridors soon resounded with the noise of Christmas greetings and exclamations over gifts. We may have forgotten that we were grown up and supposed to be dignified, but we did not forget how to be happy on Christmas morning.

On duty at seven o'clock! yes, but it is one day of the year when work is play. The Christmas spirit had entered the wards and even those patients who had little

churches sang carols on each of the wards. There were about 40 voices and the singing was wonderful. Getting out the trays with the patients' dinners was heaps of fun. We had made little baskets to contain fruit and candy. The chef had done his part and we managed to make the trays quite attractive. The patients' friends were permitted to see them at any time during the day, and it was the one time of the year when children were allowed to visit on the wards.

We had recreation hours during the day, and those who did not go out had a real Christmas dinner in the residence. General late leave was given, both Christmas eve and Christmas night, and many other favors granted.

It was altogether a very gay Christmas, and I think the secret of our happiness was not what we had done for our own pleasure, nor what we had given, but the joy which we tried to share with others.

Some workable suggestions are contained in Miss Fredericka Ackerman's story of "Christmas Eve at Fairview Hospital," Cleveland. The Candy Stick Man sounds enticing.

Christmas Eve at Fairview

Just fifteen minutes until seven, December twenty-fourth, one thousand nine hundred and twenty-one, all patients comfortable, all orders written.

Never even a peek into the classroom all day long, so surely that must be where the fun was to be. Sure enough, a splendid, stately spruce tree was placed exactly in the middle, loaded with tinsel and beautiful ornaments. Under that tree were all the presents that had been held back for so long, suspicious looking boxes that had been seen in the office.

At eight o'clock everyone was ready; even the gray tabby with her great red bow of silk ribbon was comfortably seated. The program started. First the superintendent read us the old, old story from the Scriptures and we sang, "Hark the Herald Angels Sing." Then there was the Candy Stick Man, dressed up in one of the surgeon's best white outfit with red paper stripes added and holding a big stick of candy. Some of the nurses sang songs in German, some sang parodies, some recited, others gave readings, and after all was over, what a lovely time we had opening our boxes. "Oh, look here," "See what I've got," "Oh dear, will you look what mother sent me," "Isn't that the sweetest thing?" were exclamations heard on every hand.

We always have such a wonderful Christmas at Fairview, but it is hard to think of something different to do each year.

Every nurse, however, enjoys masking and dancing, we are sure. We would suggest a Mary Jane party, or an informal party for nurses and their friends. Every training school has nurses that are talented along some line; it is nice to have a program either humorous, as we did, or otherwise.

Contests, such as orange hunts, guessing for packages, telling the most thrilling experiences, or answering the most conundrums are entertaining. Often the nurses can give dialogues imitating two well-known personages around the hospital. Such fun is sure to interest the nurses themselves, their friends and the authorities, making Christmas eve an occasion to look forward to and to be remembered.

A pupil nurse at Johns Hopkins, in her account of last year's Christmas carolling, makes the reader almost regretful that he was not one of them:

Carols at Johns Hopkins

Weeks before Christmas the markets begin to bloom with quaint things—a sort of Hans Anderson dream—celery stalks, red bells, chocolate bears, apples on sticks, mistletoe, all in a delightful jumble. Under the low sheds there is a constant jostle of laden baskets, fowls' feet protruding from one end. We buy a floating duck for our "pet baby" and have a small cold-handed lad carry home the evergreen tree for "our ward."

In all the wards the patients and nurses try to make their ward the prettiest of all. Red and green blotters appear on the desks; holly branches hang from each polished electric light; each ward has its own tree. In the nurses' home there is a tree, too, and there are spirals of greens about the pillars in the hall and tiny trees in many of the girls' rooms.

Probably those who are on night duty catch more of the spirit of it all. In the dim warmth of the babies' ward each little bed is decorated with a huge red paper bow at the head; a chubby, fragrant tree waits, the balls gleaming, dolls' arms outstretched. Over the city roofs, white with snow, the lights and stars twinkle together. Suddenly one hears "Silent Night," far down in the street below, the annual tribute of a Negro choir.

The carols are the distinctive feature of a Hopkins Christmas. We may have our individual parties and boxes from home, our own church services, dinner with friends in town; but nowhere else could we have just such carols. For weeks we have practiced them in the evening after our day's work, all the old favorites. This morning we rise at a colder, darker hour than usual, a sprig of holly pinned to our uniform capes, and two by two pass down the long corridors to sing to the patients. In the center of the hospital is a marble statue of the Christ with hands outstretched and head bowed, below which is inscribed: "Come unto me, all ye that are weary and heavy laden." Around this we sing "Joy to the World." The song rises to the galleries above and the far off dome. Still singing we march across the outdoor bridges from ward to ward. There are white nurses, blue nurses, pink probationers, led by one especially enthusiastic superintendent who leads her choir of nurses across the frosty bridges as she led others along frozen, rutted roads to sing carols to soldiers at an army hospital.

In each warm, lighted ward we file down between the rows of beds, the patients smiling and listening, some of them joining us. A few carols at each stop, and we are off again across the bridges, under the stars, to the next ward, singing as we go.

It is daylight when we finish and troop back to the nurses' home to breakfast, still singing. At dinner there are little bowls of partridge berries, or dishes of bulbs on each table. Everywhere are holly and hemlock, and nurses humming bits of carols. After a half day of work, the day is our own to enjoy in our own several ways. But whatever we do, nothing gives ourselves and others quite so much happiness as that first singing about the statue and across the bridges ward to ward. It brings us together as at no other time of year—doctors, nurses, patients in the beauty of Christmas.

An out-patients' party and a party for employes were among the delightful occasions which marked the Christmas celebration at St. Luke's Hospital, Cleveland, last year. Miss Edna Gorsuch of the class of 1923 tells of the nurses' activities in that hospital:

Christmas at St. Luke's

Christmas 1921 at St. Luke's Hospital, Cleveland, was entirely different from the usual holiday festival, yet it truly expressed the purpose of the day by giving comfort and cheer to those within its walls.

The preceding week everyone was occupied with preparation for the event. The hospital itself changed appearance. Holly wreathes, bright colored streamers and crimson shaded lights greeted one in the halls and corridors. Every room had its share—a tree and flowers for each ward. At the same time the nurses' homes were being transformed by fire places, candle lighted trees, and all devices essential for an old-fashioned Yudetide. There was much good natured rivalry concerning their attractiveness. Open house was kept during the week. Doctors and nurses visited the homes wishing each a Merry Christmas, and partaking of the hospitality extended from the bountiful boxes received from our families.

Christmas eve a party was given for the employes. The nurses entertained and each guest received a present showing our appreciation for their faithful service. We were so excited that it is doubtful if lights were out and beds occupied at their proper time. In our student government discipline was relaxed and these deviations were unnoticed.

Bright and early Christmas morning Santa distributed his gifts to us. After this joyous event we assembled in the chapel and marched through the hospital carrying lighted candles and singing carols. In response, patients doors were thrown open and in many rooms candles were lighted. The march terminated in the dining room which pleasantly surprised us with its Christmas atmosphere, including flowers, candles and a most welcome breakfast. Nothing was forgotten to insure a joyful holiday for us, even though our duties remained the same.

On the wards the patients were unusually happy, all pain forgotten. All those allowed a full diet were served a delicious turkey dinner, with place cards and favors, which had been prepared by the dietitian. The rest received favors.

Perhaps one of the most interesting sights was the children's ward. The children had asked the supervisor to tell Santa to bring each of them a toy, and were so overjoyed with her assurance that he would not fail if he had them in stock, that they could not close their eyes. Every noise was thought to be Santa entering. Finally when all had nodded off to sleep, he truly came. In the morning excitement reigned over the tree which he brought, so heavily ladened with delight for childish hearts. Never were sick children more merry.

Santa Visits Out-Patients

Not only were the children within the hospital remembered but more than 300 children who were under care of clinics were invited to the out-patient department. There Santa appeared and gave each a toy and stocking filled with "goodies." Pupils from the Music School Settlement sang carols. Cookies and hot chocolate were served. During the afternoon, members of the institution called to see the merry youngsters. Several of the staff forgot for a moment their professional dignity and entered into the jollification with as much spirit as the tiniest tot.

Our holiday season closed with a dance for the school given by the supervisors. It was held at the Cleveland Nursing Center (Perry House) and enjoyed to the utmost. Peace and good will reigned throughout our hospital. All that we may ask for our coming holiday season is a renewal of our last year's joyous spirit.

How the superintendent and faculty contributed to the holiday pleasure of the student nurses at the Lutheran Hospital training school at Fort Wayne, Ind., is told by Miss Kathryn Ganshorn in the following words:

A Lutheran Training School Christmas

Nurses who must make a special effort to keep their patients in a cheerful mood at Christmas must in turn have something to keep their spirits high, and through the efforts of the superintendent and faculty, this can be accomplished. Just to convince the reader that this can be done and was done I will tell you how the student body of seventy nurses of the Lutheran Hospital Training School of Fort Wayne, Ind., was made to enjoy the holidays even though they were far from home and friends. Our superintendent and faculty made possible the good times which we enjoyed last Christmas.

Each nurse had four hours off duty each day of the week preceding Christmas, instead of the usual three and one-half, which, with the usual Sunday and weekly half-days, gave the nurses leisure time to finish or purchase gifts.

The time for the usual Christmas celebration was set for Saturday afternoon, the day before Christmas, at three o'clock, and everyone looked forward to that time with eagerness.

For several weeks preceding, all packages addressed to nurses had been withheld by the superintendent, unless odors from within told that it contained "eats" which would not keep. If the box was opened and it contained other gifts along with "eats," only the food was removed.

Finally Saturday morning came, and each nurse awakened to find a stick of candy hanging on her door knob. Then each remembered that an alarm clock had rung wildly at an early hour on second floor. Two lively nurses got up and tip-toed to each floor, depositing on the door knob two sticks of candy on a string.

The hours dragged until three o'clock, and promptly at three each nurse was in the hall of the nurses' home waiting for the door to open. Even the night nurses were awake and ready for three o'clock; finally the signal was given by Miss Holtman, and all marched out into the spacious hall. There was a large Christmas tree all aglow, and beneath and all around the tree were piled high large packages, small packages, long packages, and even a box full of small round objects which looked very much like doughnuts, and turned out to be them.

Several hymns were sung by a selected chorus of nurses, and then the tinkle of tiny bells proclaimed Santa himself. The roll was called and each nurse received a box of candy. Santa began picking up boxes, calling off names, and handing out packages. All were remembered.

The nurses' dining room and sitting room at Philadelphia General Hospital in Christmas array

About six o'clock, hymns were sung in the halls of the hospital for the benefit of the patients, and they enjoyed it very much.

Christmas morning every one was trying to see who could be the first to wish every one else a Merry Christmas. After chapel at 6:15, hymns again were sung, this time in the front of the hospital building.

But Christmas day did not end the good times. The candy and nuts lasted all week, as also did the four hours off duty. An extra half-day was given on Monday along with the usual weekly half-day.

On Tuesday evening, a Christmas party was given, each class furnishing some entertainment. Thursday evening the freshmen held a "kimona party" up in the big Dorm. They played bunco and spent a very happy evening. Friday evening the Juniors had a banquet in the basement of the nurses' Home and what eats they did have! Each gave a toast and flashlight pictures were taken.

On New Year's Eve, a watch party was held.

Christmas at Mt. Sinai Nurses' Home

Christmas is the day of all the year when those who are away from home are most apt to have a little pang of homesickness, if not a wild longing to be with their own family. However, the nurses of Mount Sinai Hospital, New York, have little occasion for such a feeling. The "big family" spirit is predominant with this school at all times but one who has not had a part in it could scarcely believe it possible for Christmas in an institution to have so much of the holiday atmosphere and gala spirit generally as is found in this nurses' home.

A huge Christmas tree is provided and must be decorated. This occupies the spare moments of many people several days in advance and creates an air of mystery as well as happy anticipation throughout the house. Last year the tree was so beautiful that the word "glorious" was frequently heard with reference to it.

A real Christmas dinner is served, a great part of which is contributed by friends of the school.

Many other gifts are sent by members of the board of directors and by members of the hospital staff. Last year these included a handsome cabinet for phonograph records and a number of new records, and about 150 books for the library, an attractive coffee urn for the training school staff, a pound of hard candy and a pound of chocolates for each pupil nurse, and three pounds of candy for each person in an official capacity. In the picture the jars of hard candy are shown on one of the tables and the boxes of chocolates on the other.

The holiday dance affords the nurses an opportunity to extend hospitality and to share their good things with

The nurses' tree at Mount Sinai Hospital, New York

others, which is a vital part of Christmas, and at the same time adds the social feature that means so much in the life of all girls.

Miss Marcella Halm of the freshman class at St. John's Hospital, Cleveland, writes of the preparations that institution is to make for the coming holidays:

Holiday Plans at St. John's

The rooms, corridors and wards are to be decorated with their holly wreaths and Christmas festoons, each division having its own tree. On Christmas eve Santa Claus, followed by a train of nurses visits all the patients, leaving with each candy or some remembrance. He spends an hour or more with the children whose ward is to be made the happiest, gayest scene of all, with an immense tree well laden with gifts and toys.

Everything possible will be done to make the nurses' home "Christmassy" and after visits to the patients, the nurses will gather in the reception room for their big tree. A week or so before each student draws a name of some classmate and gets her a gift, appropriate to her nature or habits. They are wrapped up, verses are generally tied to them and Santa Claus, amidst much fun and laughter, reads the verses and distributes the gifts.

The midnight mass in our little chapel is a special feature. In our stiffly starched uniforms, we file in and take our places. We listen to the beautiful service, with its chants and songs, and go out with a new inspiration for the coming days.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

THE RELATION OF THE DEPARTMENT OF DIETETICS TO THE HOSPITAL COMPOSITE

BY MARION PETERSON, SUPERVISOR OF ADMINISTRATION, DEPARTMENT OF DIETETICS, LAKESIDE HOSPITAL, CLEVELAND, OHIO.

THE organization of a hospital is like a many sided polygon, each side of which represents a department. There is a department of medicine, a department of nursing, a department of dietetics, housekeeping, social service, anesthesia, etc. Each department exists primarily for the purpose of contributing to the efficiency of the hospital as a unit. Development in any one department should extend only as far as it will be a help to the whole system of organization. The ability of the hospital to function at its best is dependent to a great extent upon the interrelation existing between the various departments.

The value of hospital morale cannot be rated in dollars and cents. It is determined by the way in which each department operates. Because of the very nature of its work, the department of dietetics has an opportunity to cooperate with, and be of service to, every other department in the hospital. When the dietitian is responsible for the three meals a day there is a direct point of contact between the department of dietetics and every individual in the hospital.

Must Vary Food for Personnel

The problem of feeding doctors and nurses is enormous. Many of them are residents for long periods of time during which the best of institutional food becomes monotonous. Therefore no effort should be spared in planning meals which will give satisfaction. This element is maintained only by including a variety of well prepared foods in combinations which will be surprising and interesting. Moreover, the term variety does not necessarily imply the use of the most expensive foods. Where the workers are fed adequately and to their liking they will be less disposed to purchase food elsewhere, a thing which many of them cannot afford to do. They will be happier and healthier, and able to maintain a higher level of efficiency in their work.

Good service to the personnel of the hospital also means that doctors and nurses detained until late in the operating room or on the wards will be given special attention. They will be served a hot, palatable meal instead of cold left-overs. Night nurses will receive freshly prepared, tempting midnight suppers, rather than food which was salvaged from the noon meal. Nor will these efforts go unappreciated. Furthermore, the serving of meals which satisfy will result in a decrease in food waste. More of the food prepared will be eaten and less relegated to the garbage can. It frequently happens that a special diet is ordered for one or more of the hospital employes who are under medical supervision, but are not bed cases. It is difficult to provide this diet through the regular dining room service. One solution has been offered in the establishment of a special dining room in connection with the diet kitchen. Meals are prepared and served by the nurses as a part of their special diet training.

Individual Consideration to Patient

The direct relation of the department of dietetics to the medical profession may be reached through the patients themselves. Dietetic treatment will be based on the principle that each patient is an individual, and entitled to the same individual consideration where diet is concerned, as he is given in the field of medicine or surgery. This becomes possible when the dietitian may visit each patient. With a knowledge of his food habits, as affected by racial and religious customs, and the probable amount of money which the patient can spend for food at home, she will be able to plan his diet intelligently. It will be suitable to the metabolic disorder as well as pleasing to the patient. If an Italian received an occasional dish of spaghetti, or a Scandinavian his pickled herring and boiled potatoes, how very much more contented he would be! He would feel that someone had taken an interest in him, and that a hospital was not such a bad place after all.

Very frequently the dietitian finds it difficult to prove to the doctors the value of dietetics. She should spare no effort in doing her best to help the doctors to obtain results with their patients. Our experience has proved that when serious effort has been put forth the doctors have responded with an attitude of splendid cooperation and a willingness to acknowledge the value of the department.

Must Educate the Patient

The relation of the department of dietetics to the patients does not end when the patient leaves the hospital. For some time prior to his time of discharge the patient will receive instructions concerning his diet in the hospital and its readjustment when he goes home. Frequent home

visits will be made by the instructor in the food clinic, in order that he may receive help and supervision during that period of readjustment to home conditions. Since most of the ward cases become dispensary cases for follow-up purposes, the department of dietetics still has an opportunity to be of service to the medical profession. The dispensary or food clinic work suggests other possibilities. Medical care plus dietary supervision may be the means of preventing the need of hospitalization in many cases. The following case which has been brought to our attention serves to illustrate the point:

Mr. H. was a night watchman on the point of giving up his job because of illness. A diagnosis of duodenal ulcer was made. Medication and a restricted diet were begun at once. Home visits were made by the instructor in the food clinic, and the patient's wife was enlisted in the service. She received instruction concerning her husband's food, with special attention paid to the midnight lunch. The results were interesting. After two months' treatment there had been a continued absence of pain and a gain of thirty pounds. Mr. H. did not lose a day's work and was able to keep the family on its feet financially. Dietetic and medical supervision are to be continued indefinitely.

How very much better it is to keep the patients out of the hospital when possible, thus leaving a greater number of beds available for other cases!

Work of this kind brings a point of contact with still another department, namely social service. Very close cooperation is possible on cases of this kind from which the social worker and the instructor in the food clinic may derive mutual benefits.

The educational function of a hospital should be extensive in its scope and show clearly the interrelation of the composite parts which go to make up the organization.

It should be made possible for the patients to assimilate much knowledge while they are under our care. If a man comes into the hospital with a broken leg and goes home having received nothing but surgical or medical care for the injured member, the hospital has not made the most of its opportunity. He might have learned much about hygiene or sanitation as well as about food. All patients who are visited by a dietitian may be taught why certain foods were used, how they were prepared, and how they may fit into the family dietary, when the patient returns home. Recipes should be given out at the time of instruction.

Pupil Nurses Must Be Taught

The teaching of pupil nurses holds an important place in the educational program of the hospital. Recent knowledge of dietetics has created a widespread interest within the medical profession. Realizing the soundness of dietotherapy, many doctors are demanding a great deal more of this knowledge from their nurses. Public health and school nurses are looked up to by mothers and children and are supposed to be an authority on all questions of diet as well as medicine. Therefore pupil nurses must be trained to meet the increased demand for this special knowledge. It will be possible to obtain this knowledge only by actual case work. They should follow the diet from beginning to end. They should plan, prepare, and serve all food to the patients assigned and record the food intake of the patient. By personally serving the tray to the patient, the nurse will take an interest in the individual. Consequently she will use greater care in planning and preparing his diet. Complete records of the food intake of the patient will be available at any time for the doctor. This intensive dietetic training for the pupil nurses will be possible, of course, only with a full time instructor in the diet kitchen.

In connection with the educational aspect of hospital dietetics, it might be interesting to mention an arrangement which exists at the University of Michigan Hospital. Some of the convalescent children and others who are able to be up come together at one time for their meals. Small tables and chairs and dainty dishes are provided, and special effort is made to teach the children to like the food which is good for them. The mothers are frequently present at this proceeding, the value of which is probably twenty-five per cent to the child and seventy-five per cent to the mother.

Instruction to Other Groups

There are many other groups of people who may be glad to accept the instruction the hospital can offer through its department of dietetics. In some institutions the interns are given instruction in practical dietetics to supplement the theoretical knowledge they have received during their training. There are also the student dietitians who must depend so much upon what they can derive from their course of apprenticeship. The department of dietetics should be maintained with the finest possible organization in order that these students may receive the right sort of background.

In this connection there is frequently an affiliation between a university in the community and the department of dietetics. One university at the present time offers to senior students in home economics a course giving nine hours a week in the department of dietetics in a nearby hospital.

One hospital has made it possible for many of its employes, namely the maids, to receive regular class instruction on hospital time. With an arrangement of this kind they may be taught principles of hygiene and cleanliness, as well as simple cookery. There is an opportunity to teach them food economy and how in their homes they may achieve a good variety of food on a limited income. There are two points of significance suggested here; the cooperation which this work would necessarily bring about between the departments of dietetics and housekeeping, and the influence it might have upon the community.

The place of the hospital in the community is composite. An attempt has been made here to suggest a variety of ways in which the department of dietetics may contribute its share toward the general usefulness of the hospital. What the hospital, through the department of dietetics, contributes to the community will be not the ideas and policies of this individual department but the dietetic ideas and policies of the hospital administration.

NEWS ITEMS

The Allegheny County Dietetic Association held its October meeting at the Mercy Hospital, Pittsburgh, Pa. The entire meeting was devoted to business, since the first meeting of the fiscal year took the form of a swimming party at the McKeesport Hospital.

The program committee presented a tentative program for the entire year. A special committee appointed by the president, submitted a constitution and by-laws for corrections or approval of the house.

Miss Adeline Wood who was for a short time assistant dietitian at Mount Sinai Hospital, New York, is with the Shraft Company in New York. Her successor at Mount Sinai is Miss Rosina Vance. Miss Vance was at one time dietitian in a hospital in Porto Rico and more recently a student in the metabolism ward at Presbyterian Hospital, New York.

Miss Lucile Nusbaum and Miss Olga Young recently finished student dietitian training at Mount Sinai Hospital, New York. Miss Nusbaum has been retained as teaching dietitian, and Miss Young is assistant dietitian at Montefiore Hospital. These are the first students to finish student training under the new organization.

BY-PRODUCTS FOR THE CHILDREN

By ANNA WEEKS and BERTHA WOOD, Northfield Seminary, Northfield, Mass.

"MOTHER, I don't want any cereal this morning." 'Twas the same old story so familiar to many.

"But you've forgotten, Lucy, what's going to happen when the box is empty."

"Oh, goody! So I had, but I won't forget again for I want to find what you've promised in my stocking on Christmas morning. And I'll eat the cereal every morning so there'll be more than one thing."

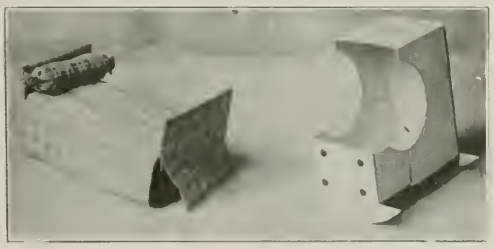
Lucy and her mother were all that were left of a once prosperous family. The money laid by by the father and husband had gradually slipped away until nowadays there was nothing to be spent for toys. But one day at the Mother's Club in a nearby health center the mother learned that although she kept her money for the purchase of food there were by-products to be turned to good account and she went home with a great joy in her heart.

Lucy's mother had never been clever with her needle, nor was she ingenious in the use of left overs. What she did, she did well but there was little variety in her life and Lucy's. That day at the Club, however, opened up a new field and success in it meant much happiness for her child, the little girl who had been deprived of much that other children had. The incentive was great and the possibilities grew upon her as she thought of one thing after another that the lesson at the Club suggested.

Let us follow her in her dream to see what she was seeing and making.

Doll's Chair from Pettijohn Box

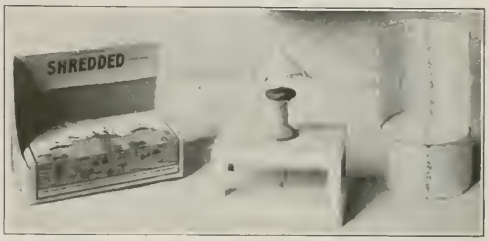
First a doll's chair made from a Pettijohn box. Remove the cover and cut off the rim, draw a line 4½ inches long perpendicular to the top edge of box. Draw



another line 4½ inches long on the opposite side of box. Connect the lower ends of the two lines. Remove the piece enclosed by the three lines with a sharp knife. Insert the piece removed inside the box opposite what is to be the front of the chair so that it rests on the bottom. A little glue will hold it firmly in place. Put glue around the edge on one side of the circular piece which formed the corner and use to form the seat.

Sample wall paper books can often be got for the asking and may be used to good advantage in covering the chair and other pieces of furniture. By using a little care the separate parts can be neatly covered and and then put together. Cretonne coverings can be used but usually require some expenditure and more time in fashioning.

From a shredded wheat box a settee can be made. Start with the box opened in the ordinary way. Cut down the two front edges 3⅞ inches. With a sharp knife score across the front of box to connect the lower ends of cut edges. Fold on scored line and bend at right angles to form seat. What originally was half of cover



will lie parallel with back of settee and may be fastened to it securely by means of glue, a few stitches or two brass fasteners. On the two ends indicate the shape desired by pencil lines and cut along the lines. Fold down the second half of cover against the back of settee and fasten.

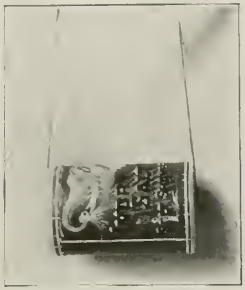
For bedroom use, a puffed wheat box, if it has been opened carefully, will make a bed. With a sharp knife make a slit from top to bottom of the front of the box midway between the sides. Cut along the upper and lower edges of the front and continue down both sides 2⅛ inches. Draw lines on the sides of the box connecting the points 2⅛ inches from the corners and score with a sharp knife. Bend on scored lines and fold at right angles, first one side and then the other, forming a double bottom on which to lay the mattress. Out of cretonne make covers with ruffles across the bottom to slip over the headboard and footboard, also a cover with ruffles, along the sides to lay over the bed. If this is lined with a layer of cotton batting and a roll made for the pillow a pleasing effect is secured.

Correspondence cards boxes are invaluable in the making of furniture. From a cover a table can be made by cutting out an oblong from each side leaving four legs, one at each corner, for it to stand on. If a shelf underneath is desired, outline an oblong on each side with pencil. Cut along the upper edges and two sides of the oblongs and score on the lower edges. Bend along the second edges at right angles and cover shelf with figured paper to match that used on top of table for a covering.

Making a Cradle and Lamp

A cradle can be made by using the whole box, the cover standing upright to form the hood and the inside of the box forming the bed. Rockers should be cut from cardboard to fit the two ends and all the parts fastened together with brass fasteners. To improve the appearance cut semi-circular pieces from the free edges of the hood about half way between the top and bottom and shape the bed to correspond with these.

A lamp for a table is made with a large wooden spool as a foundation. Make a tight roll of paper, long enough to form the height of the lamp and of the right circumfer-



ence to fit inside the spool. Insert in the spool and on the top hang a shade made of a circular piece of bright colored paper fitted to give the desired slant and fastened together with glue or by a few stitches.

The toddler must not be left out at Christmas time and for him a salt box will find a use. Purchase a small bell with a few pennies and put together with three or four huttons on a long string. Run the string through the two ends of the box, leaving the bell and buttons inside. Tie the string securely, fasten on the cover of the box with glue and the rattle to be drawn over the floor is complete.

Together with Lucy's mother we might go on indefinitely and find ourselves surrounded by rocking chairs, mirrors, bureaus and what not, but these few things made for Lucy,

A MERRY CHRISTMAS!

CHRISTMAS RECIPES

Peanut-Stuffed Goose, with Grapefruit Sauce

Select a fat goose, and after preparing for stuffing, let soak for an hour in a mixture of equal parts of vinegar and water. Meantime, prepare the following stuffing. Mix one cup of bread crumbs with one cup of finely chopped peanuts. Add one-half a cup of cream, heated with two tablespoonfuls of butter, until the butter melts. Season with one teaspoonful of salt, one-half a teaspoonful of pepper, one-half teaspoonful of dried powdered thyme, and one tablespoonful of scraped onion or onion juice.

Pare, core, and quarter one or two sour apples; stick two cloves in each quarter, and mix these with the stuffing; fill into the body of the goose and roast as usual, basting frequently. When done sprinkle with powdered dried sage, and serve with grapefruit sauce. (Recipe No. 4.)

Pear La Reine

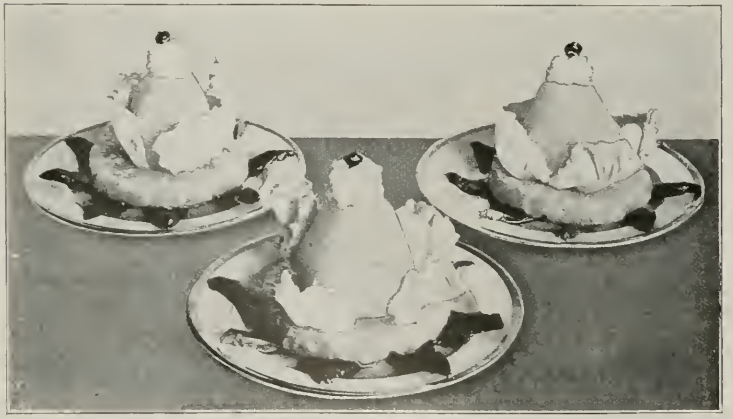
Arrange points of red, sweet pepper about a slice of canned pineapple. With a sharp pointed knife remove the skin, core and stem from a choice Bartlett pear; stuff the cavity with equal parts of chopped nuts and pine apple; decorate the top with cream cheese and a Bar-le-Duc currant. Set the pear on the slice of pineapple, and around the base of the pear arrange small heart-leaves of lettuce, filled with cream cheese.

Small Decorated Sponge Cake

Beat three eggs until very firm; gradually beat in one cup and one-half of sugar and the grated rind of a lemon; then add alternately, one-half a cup of cold water and one cup and one-half of pastry flour, sifted with two teaspoonsful of baking powder and one-fourth of a teaspoonful of salt. Bake in a sheet. When cool cut in shapes with round or oval cutters, covered with boiled icing, and decorate with strips of angelica and chopped pistacho nuts.

Grapefruit Sauce

Toast in the oven, until hard and nicely browned, enough sliced stale bread to make a cup of crumbs when rolled and sifted. Mix these thoroughly with one-quarter of a cup of melted butter, seasoning of salt and pepper, two tablespoonfuls of tomato catsup, one cup of grape juice, and one well-beaten egg. Cook, stirring carefully, until egg is set sufficiently to make the mixture slightly creamy. Before serving stir in one-half cup of of any tart jelly, the wild grape jelly is best, first pressed through a potato ricer. This is a good sauce for game, the fatter kinds of fish, or any red meats.



The Allegheny County Dietitians Society held its annual banquet at the Hotel Chatham, Pittsburgh, Pa., on November 1, at six-thirty o'clock. The tables were beautifully decorated and a very good four-course menu was served. A short discussion of the meetings of the American Dietetic Association Convention which was held in Washington, D. C., in October, took place. This was followed by a presentation of wedding gifts to two of the members who were recently married. Most of the members of the organization were present and spent a most enjoyable evening.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

FOLDING GOODS IN THE HOSPITAL LAUNDRY

By WALTER T. WILLIAMS, Cincinnati, Ohio.

IN AN article in the September issue there was specified in a general way the positions in which identification marks may be placed on different articles, with a view to the greatest convenience to the greatest number. To get the full benefit of this or any other standardized marking system one will need to have a standardized system of folding which brings the respective marks to a place where the assorter always will find them. Hence there shall be described the folding of the principal articles that come to the hospital laundry, using as many illustrations as are necessary to make the matter plain.

First will be considered the flat work, for most of the goods that enter to the hospital laundry comes under this heading. In some hospitals, especially the smaller ones, the flat work does not bear an identification mark, but whether it is marked or not, a uniform method of folding is desirable.

To meet requirements of the linen room, such as the size of the shelves, some changes may have to be made in this schedule for folding the goods, but as a rule this will only involve the addition of one fold in some cases and the omission of one fold in a few others. In nearly every case the first, or basic, folds may be used as indicated.

In a few cases it may be well to make a few minor changes in the linen room, in order to make matters more convenient for the laundry department. The two departments are so closely related that they should be carefully coordinated. In the Cincinnati General Hospital, where some of the data for this article were gathered, one person is superintendent of both the linen room and the laundry, and therefore there is always harmony between the two sections.

The folds which I suggest are those which were found to be in use in the greatest number of hospital laundries, after a careful survey of several well-conducted ones. In many cases the commercial laundry folds articles differently, because of wrapping requirements.

Flat work is nearly always folded by the operatives as it comes from the flat work ironer. Usually there are two persons at the end of the machine where the work comes out, commonly called the "back," when sheets or other large pieces are being ironed, but in case of the smaller and slower machines there may be only one person at the back. If there are two persons, the first fold of a sheet or other large piece is made by the two bringing the corners together, one holding the center. One person, however, if skilled, can fold sheets as rapidly as they come through a small machine.

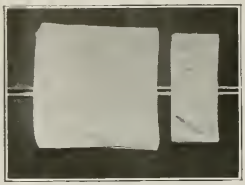
If the reader will follow the illustrations that appear

First Two Folds of Sheet
The arrow at the back points to the first fold which extends along the table. The other arrow points to the second fold of another sheet.

Third, Fourth and Fifth Folds of Sheet
The third fold is indicated by the arrow in the foreground. The fourth fold is shown in another sheet and the fifth in still another.

herewith the descriptions of the folds may be more readily understood. It is difficult to describe the folding routine in some cases and in others it is impossible to state them with absolute clearness; therefore one must sometimes be guided by the photographs.

Sheets.—The sheet shown is 72 by 99 inches, and the folds are as follows: (1) across the narrow way, in center; (2) at right angle to 1, in center; (3) parallel to fold 2, in center; (4) at right angle to 3, in center; (5) parallel to 4, in center.



Folds of Bath Towel

The first and second folds of a medium-sized bath towel are shown in the above illustration. The third fold would be at right angle to the second, in center.

Crib sheets.—These are 63 by 90 inches. Fold the same as the regular sheets.

Spreads.—Usually these are folded the same as sheets. Some housekeepers prefer that the first fold be lengthwise, in center, with second fold parallel to it.

Draw sheets.—Usually these are about 54 by 72 inches, and they may be folded the same as regular sheets, omitting fifth fold.

Folds of Large Handkerchief

The above illustration clearly shows the folds of a large handkerchief. In case of small handkerchiefs the fourth fold is omitted.

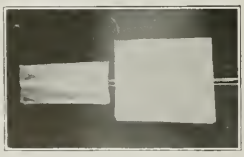
Pillow slips.—(1) across narrow way, in center; (2) parallel to 1, in center; (3) right angle to 2, in center. Some fold them: (1) lengthwise, in center; (2) parallel to 1; (3) across center, narrow way. The first way gives the more stable pile, however.

Tablecloths.—There are many sizes of tablecloths, so the number of folds must be adjusted to suit each case. Ordinarily the folds for a sheet or a draw will bring them to a convenient size.

Bath towels. — These also come in various sizes, but the ordinary folds are: (1) narrow way, in center; (2) parallel to 1, in center; (3) at right angle to 2, in center. Larger sizes may be given a fourth fold. Some make the first fold lengthwise, in center.

Hand towels.—For ordinary size: (1) lengthwise, in center; (2) at right angle to 1, in center. Sometimes 2 is parallel to 1.

Large handkerchiefs.—(1) Lengthwise, in center; (2) parallel to 1, in center; (3) right angle to 2, in center; (4) parallel to 3, in center.



Folds of Pillowslip

The above illustration shows the first two folds of a pillowslip. The third fold would be at right angle to the second, in center.

Small handkerchiefs.—Same as large, omitting fourth fold.

Operating linen.—Fold same as regular linen of same size.

Napkins.—There are so many sizes that it is not expedient to indicate all folds. Ordinarily they may be folded the same as large handkerchiefs. Sometimes they are delivered flat and folded by the waitresses, frequently in fancy shapes.

Blankets.—Although these are not, strictly speaking, flat work, their folds will be described. Fold (1) across narrow way, in center; (2) right angle to 1, in center; (3) right angle to 2, in center. Large blankets may receive a fourth fold.

The foregoing list embraces nearly all of the pieces of flat work that come to the average hospital laundry. In rare cases a hospital may have a large number of special articles, and in that event it will be hard to devise a standard method of folding such pieces.

Folds of Hand Towel

The folds of a small hand towel are indicated by the arrows in the above illustration. The crease in the bottom towel indicates another method of folding, which makes it convenient to hang towels on a rod.

As with marking, there should be a written or printed schedule for folding, and this should be where all can study it and commit it to memory. It may be this plan, or it may be another, but there should be prescribed methods which all must follow. In some laundries there is no uniformity whatever either in folding or in marking. Each operative has been taught a different method in some other place, and as each brings a different way with her, confusion prevails.

In the next article there will be discussed and illustrated the folding of the principal articles of bundle work, or the personal articles of the personnel of the hospital. While these do not form as great a bulk as does the flat work, the correct folding of them is equally desirable.

NATURE'S BOOKKEEPING

Nature has the most complete and exhaustive system of bookkeeping yet devised. A separate and distinct account is opened with every individual the minute he comes into this world and always he is permitted to stretch his credit to the limit. Nature exacts full pay and final settlement from all alike.

Nature has provided a time for work, a time for play and a time for rest and sleep. It is her intention that we shall work in harmony with her laws as much as possible. We have a thorough understanding of her terms, discounts and datings and if we try to practice any irregularities we are promptly notified through her faultless system of doing things.

It pays to keep your account with nature well under your own control. No one can realize on his ability in any fair way unless he starts out in the morning with that freshness and freedom of mind and body that comes only from proper rest and sleep.

Optimism is hope brought down to the present and applied to the thing you expect to tackle next. It is an individual quality which can be acquired and developed just the same as systematic exercise will develop knots of muscle on the arms and shoulders. If you feel there is a chance for developing your optimism, start in training now and go out each morning with your head up and your eyes fixed on victory, practice the bright outlook in every word and gesture; carry plenty of the ointment of good cheer wherever you go and see how much more smoothly things will run with you.

SELECTION AND SUPERVISION OF HOSPITAL SERVICE EMPLOYES

By C. W. MUNGER, M.D., Superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.

BEFORE a hospital begins to look for employes with which to man itself, it is essential that a clear cut plan of organization be thoroughly worked out and agreed upon. The lines of authority must be plainly defined. Every employe must know to what person he is responsible, and he should not be directly responsible to more than one person. It may become necessary in small institutions for an employe to devote part time to each of two or more departments, but the arrangement is certain, sooner or later, to cause friction.

Methods of securing employes must be accommodated to local conditions. The employment agency is frequently helpful, but when persons of skill and training are required it is better to use newspaper want ads. Employment agencies suffice for laborers, unskilled firemen, yardmen and scrub women. Newspapers give better results for cooks, assistant engineers, painters, carpenters, seamstresses and other skilled workers. The newspaper reaches the class of employes most frequently desired, namely, the skillful man or woman who is already employed but who may be willing to make a change. Frequenters of employment agencies are likely to be chronic job hunters. It is better to secure tried employes—people who have made good in similar work elsewhere and who understand the nature of the task to which they will be assigned. Even though they may cost more, they are far more certain to be permanent and valuable. It is more desirable to secure employes whose homes are in the city in which the hospital is located. It is perhaps better to get along with a less skillful person living nearby than to "import" an experienced worker, who is very likely to be dissatisfied in a strange city and to find living away from home expensive.

Should Be Able to Read Character

Persons who can judge skillfully as to the character of applicants for positions are paid generous salaries by large corporations. Since a person of this type is seldom available for a hospital, the superintendent, the steward, or other employing officer should develop the above mentioned faculty insofar as possible. It is well worth while for this person to study some of the more recent books or courses on character reading. Given a person who seems desirable from the point of view of personality, character and experience, the employing officer should consider also the age of the applicant. It is desirable to avoid the extremes of age excepting in special cases. Young people who are just starting to work are naturally less experienced and are a little more likely to be unreliable. Elderly persons are not good risks if taken as employes for work which they have not previously done.

A hospital superintendent is often tempted to employ some of the unfortunate ex-patients of the hospital, who are partially incapacitated. Such a plan, while altruistic, is unwise. The writer believes that the patient for whose welfare the hospital is responsible, has a right to expect that those who attend his wants shall be strong and healthy. The psychic effect upon patients and visitors of seeing cripples or other unwell people acting as employes in the hospital also is not to be overlooked.

Every applicant should be asked for references, and these should be looked up. It is always well to inquire as to family connections and responsibilities. If an able bodied man with five children applies for a position at $60 per month, any employing officer will know that he will hold the job only until he can get something better. It is never wise to intermingle races in an institution. This is frequently obligatory, however, and if so there should be as much segregation as possible.

A type of employe which should occasion suspicion at once is the man or woman who immediately adopts a free and easy, unabashed attitude, something similar to that of a really efficient employe who has been with the hospital for years. This individual will usually do passable work in the beginning, but will be rather too much inclined to make suggestions regarding improvement of methods to his fellow workers and to his superior officers. This person is one who is most likely to fail miserably in any position. Reserve, a quiet, unassuming or even bashful manner, are usually indications of worth.

Physical Examination for Employes

A physical examination, including Schick test, smallpox vaccination and tests for active venereal infection, should be made on every person working in a hospital and should be repeated periodically. Hospitals have been almost criminally slow in adopting methods of this sort. We are especially put to shame by our friends, the manufacturers, in this regard and, moreover, the manufacturer has not one-tenth as much to lose because of the unwell employe as has the hospital.

Wages are usually a local matter. The hospital should not attempt to get employes at rates appreciably lower than is paid for similar work in other types of institutions in the same locality. Every employe should be started at less than the maximum salary. Persons doing identical work should be paid the same, excepting that seniority in service should receive some recognition in the pay check. Every employe in the hospital should be placed on a monthly basis as to pay. He should be paid twice a month or, if possibe, once a month. This is especially desirable if the hospital issues monthly financial reports. The hospital that pays by the week is decidedly hindered in getting out true financial reports, especially in those months having five weekly pay days.

Much has been written regarding the housing of hospital employes. In certain instances it is actually necessary for an institution to provide room and board for all of its employes. It is certainly not as invariably necessary as seems to be generally supposed by hospital people. Blodgett Memorial Hospital is located outside the city limits of Grand Rapids and is distant from the section of the city usually occupied by working people. It has had little or no difficulty during the past winter, although it houses only two per cent of its male and fifteen per cent of its female service employes. It is desirable to keep in the hospital a few especially essential workers, usually including the cooks who must go to work very early in the morning. Much worry and convenience will be avoided by having all other employes reside and get their meals outside. It costs our hospital approximately $30 per month to house and feed an employe. It has been observed

by us, however, that very few employes are willing to give maintenance this valuation when naming their salary. It has been observed that an additional $20 per month is considered sufficient compensation for lack of maintenance. Employes are more industrious, more contented, and more efficient when living outside the hospital. Moreover, the officers of the hospital are relieved of the responsibility of enforcing hospital rules in relation to employes' deportment when off duty,—often an arduous task.

Employes who do live in the hospital should be given comfortable quarters, not more than two in a room, and should be required to be careful housekeepers. They should be supplied with adequate bathrooms and sitting rooms. A place to eat noon-day luncheon is desirable when employes live outside. Only those employes who must live in, should receive their meals at the hospitals, and they should be given food equal in quality to, and in greater quantity, than that of the nurses.

Ironclad Discipline Has Disappeared

Just as the ironclad type of discipline is disappearing from nurses' training schools so is it less frequently seen in the service departments of the hospital. There is no excuse for any department head failing to exercise politeness and kindness with his employes. Consideration of the employe's feelings will always be appreciated. Firmness, of course, is absolutely essential, but the executive should assure himself, when he feels that firmness must be exercised, that he, himself, is just and not merely stubborn.

The writer believes that resignations should always be accepted. There is a certain type of employe, who, realizing that he is valuable, will threaten to resign the moment that anything goes contrary to his wishes. This type of person is always a source of irritation. If his "bluff" works once, he will repeat it frequently. Let your people know that you take them at their word, and the "chronic resigner" will disappear. In matters of this kind it is hardly necessary to say that employes should be managed, insofar as possible, through the department head. If an employe comes to the executive with a complaint, he should always be referred to the head of his special department, and a conference should rarely be held with him excepting in the presence of the department head.

We are all familiar with the employe who is classified as the "chronic grouch," "the plotter" or the "trouble maker." A whole group of employes has, in my experience, been influenced almost to insubordination by one unprincipled person. The solution of this problem is obvious; and results are invariably gratifying.

Favoritism is difficult to avoid, but it should be guarded against as a sure cause of dissatisfaction and legitimate criticism of the executive.

Disloyalty to the institution or to its officers should not be countenanced. On the other hand, it is possible to develop in many employes a spirit of loyalty and interest in the welfare of the hospital, which will react more favorably upon their efficiency than either censure, approbation or increased pay.

BABY DRESSING TABLE

The question of dressing infants is a perplexing one and lives have been jeopardized for want of suitable means for accomplishing that task properly. The importance of equipment and facilities which will assist in the proper dressing of infants is at once apparent when it is realized that no effort is too great or too costly to save lives endangered by ill health.

A table designed for the convenience of the nurse and constructed on aseptic principles, having individual compartments for toilet articles as well as an electrically heat regulated compartment for the clothing of the infants, cannot fail to appeal to those in charge of nurseries and babies' wards in modern hospitals.

Recently there has been placed on the market a baby dressing table constructed of white enameled silver furniture steel and seamless tubing with nickel plated trim-

mings. The table is of a size sufficient to allow six infants to be dressed on it at the same time. Two drawers to hold toilet articles and one drawer enclosed in an electrically heated compartment, to hold the infant's clothes are provided for each nurse.

The electrical equipment is so arranged that each compartment may be heated at various temperatures or may be turned off without affecting the other compartments. The top of table is perforated to allow a sufficient amount of heat to radiate and warm the space where infant is being dressed.

In size the table is 48″ wide, 84″ long, 36″ high, and has a height over all 44″. It is finished in ten coats of hand rubbed, baked white enamel and mounted on hardwood plugs.

NURSES' INSTITUTE IN NEW YORK

The bureau of public health education of the New York department of health is contemplating giving a five-week institute for nurses, beginning in January. The institute will cover the following subjects: industrial hygiene; preventable diseases; child hygiene; district nursing; Henry Street Settlement (courtesy of Miss Goodrich); home care of the sick.

It is hoped that the nurses who desire to take this course will register at the earliest possible moment and that so far as possible they will arrange to take the field work. This will necessitate accompanying the members of the particular organization cooperating for that week in their regular field work. Instructions in the technical part of the work will be given in the headquarters of the different organizations by qualified members of their staffs.

Occupational Therapy and Rehabilitation

Conducted by HERBERT J. HALL, M.D., Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS.
Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and
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THE CHRISTMAS ROLL CALL

HOSPITAL occupational therapy departments are particularly active during the Christmas holidays. Days in a hospital are what the patients make of them. For guidance and inspiration the patients need the occupational therapist who is responsible for the morale, optimistic outlook and spirit of the patients. If those who are without the hospital walls to whom life is full and rich feel a quickened heart throb at Christmas time, how much more significant is Christmas to those who have come close to suffering and sorrow. There is a consecration in making a happy time for those who will not know another Christmas, and Christmas preparations touch a cord in hardened and discouraged hearts that must be made to vibrate for those who are to be made well, so that these sick may once more feel themselves a part in the world-wide spirit of Christmas. The preparations, the music and the celebration itself are new stimuli which the therapist is eager to develop along constructive lines that the value may be permanent to the patient and may provide the great moralizing forces of interest outside the hospital—thought and consideration of others in community effort and social adjustment.

For the therapist Christmas is the one great opportunity of the year to take patients outside of themselves, and to recreate them, body and soul. The preparations cannot begin too early, and the inspiration and reawakening must be made to last throughout the year.

How Christmas was celebrated last year in a number of hospitals with active occupational therapy departments, is told in the following paragraphs:

Illinois

Kankakee State Hospital

Before Christmas last year every ward and cottage at Kankakee State Hospital were resplendent with decorations, many of which were made by the patients in the occupational therapy classes. The wards vied with each other in trying to have the most tastefully decorated quarters. Last year the real activities began on Christmas Eve. Every seat in the large auditorium was filled with patients. There was a regular Christmas entertainment with readings and music, and best of all a huge tree and a Santa Claus. This program was taken care of by the chief nurse, Miss Hattie Levreau.

Christmas day began with mass at 7 a. m. for the Catholic patients, after which an orchestra accompanied by the managing officer, officials, and employes visited every ward and cottage in the institution, greeting the patients and wishing them a Merry Christmas. The dinner was served at 1 o'clock, and at 2 p. m. there was special religious services for the Protestant patients. On Monday evening, the 26th, there was a magic art entertainment, given by a professional; on Tuesday evening a dance for the patients. Wednesday evening there was a musical and literary program, under the direction of Miss B. E. Sutton, the chief occupational therapist. The cooperation of the Metropolitan Musical College was secured, and its best talent was brought to the hospital. The program consisted of vocal solos, violin and piano solos, esthetic dancing and readings. On Thursday evening a motion picture show and vaudeville performance was held under the direction of Miss Edna Benjamin, the physical director. Patients and employes furnished the vaudeville acts.

On Friday afternoon there was a party and entertainment for the patients of the occupational classes. More than 700 patients attended. For the most part they were patients not well enough to attend the Tuesday night dance. Refreshments were served to all of the patients at this party. On the same evening there was a musical entertainment given in the chapel, under the direction of Mr. D. C. Lint. The week's activities closed on Saturday evening with a grand masque ball. Patients and employes came in masquerade costume. This is an annual affair and is always looked upon as one of the very happiest entertainments of the season.

Indiana

Marion National Sanatorium

Christmas of 1921 at the Marion National Sanatorium will long be remembered by those who participated in it as one abounding in joy and good will. It was the first Christmas after the conversion of that national military home into a neuro-psychiatric sanatorium, and it was the wish of the medical director that not only Christmas day, but all the week be given over to the entertainment of the patients, and be made a red letter week in the annuals of the home. With that in view, the entertainment committee, composed of the heads of all departments in the sanatorium in any way responsible for the patient's care and well being, were called together late in November to plan and carry out the comprehensive program. Every department in the institution was made responsible for certain features of the program, and there was more than ample work for all in carrying it through to a successful finish.

The occupational therapy department was charged with the planning and preparing of suitable decorations, both for wards and Christmas trees. Realizing that the

quickest and surest way of arousing the Christmas spirit in the patient was to give him a definite part to play in the preparations, it was determined that all other work in the department should be set aside for two weeks before Christmas, and that the aides should bend all their efforts toward enlisting the patients' interest and cooperation. The result was that within a week, not only the patients assigned to occupational therapy, but every patient who was well enough to hold a piece of gay paper or paint brush in his hand was assisting. As a result of the patients' efforts 200 cedar wreaths, 1,500 tree ornaments, and Jacob's ladders without end, were made so that every ward as well as the mess hall and the building used for the Christmas parties were supplied with a generous share of decorations. In addition to that, prizes were offered for the most attractively decorated ward. The patients entered into this with zest, some of them working until taps on Christmas eve to perfect their scheme of decoration.

Manitoba

The Society of Occupational Therapy held a Santa Claus sale last year in a prominent downtown building in Winnipeg.

Dainty baby clothes, pretty sketched crib spreads and unique wood toys form part of the attractive display. Baby crib covers sketched with nursery rhymes and pictures composed one of the interesting booths. Leading artists of the city contributed their talent to the beautiful applique articles. Fascinating appliqued playsuits and unusual knitted suits were among other specialties.

Basket work done by the blind showed some splendid samples of their wares. Chairs, piano benches and various pieces of furniture were all well made and substantial.

Grown-ups had a variety of gifts from which to choose. Scarfs, hand-woven bags, baskets, lamps, enamelled wood carving and embroidery and other handicraft work by the patients of Tuxedo and Selkirk hospitals and the Winnipeg General Hospital psychopathic ward were on view.

Lady Aikins and Mrs. Edward Parnell opened the bazaar in the Fairies' tea room. Santa Claus distributed gifts to the children.

Proceeds derived from the bazaar are to be devoted to establishing a community workshop where disabled persons can be trained for useful occupations.

New York

Middletown State Hospital

Last Christmas Dr. Maurice C. Ashley, superintendent of the Middletown State Hospital, tried an interesting experiment on one of his most distributed wards for women patients. The patients were asked if they would like to decorate their ward for Christmas and as most of them indicated a willingness to participate in the work, those who were able went with nurses and attendants to nearby woods and collected a considerable quantity of evergreen vines and branches. These were brought back to the ward and woven into wreaths and streamers for ward decorations. Some red paper bells were purchased and the patients, with the help of the attendants and nurses, decorated the ward. Most of the patients manifested an active interest in the work and were highly gratified at the result when the decorations were completed. It had been prophesied that the draperies would all be torn down within a short time, but these prophesies did not come true. So much did the patients appreciate the change of environment that at the end of two weeks when the greens were taken down, it was found that none of the decorations had been destroyed or disarranged.

Municipal Hospitals of New York

For many years the New York city visiting committee of the State Charities Aid Association has made an especial effort at Christmas time to supplement the work planned by the city and by the other organizations to make Christmas as happy as possible for the sick and the aged of the municipal institutions. Especial emphasis has always been laid upon Christmas music, which can do more than anything else to produce the real spirit of Christmas.

Through the committee's efforts the choir from the Cathedral School of St. John the Divine sang on the Monday before Christmas in eleven different wards of the Metropolitan Hospital, of the Central and Neurological Hospital, and of the City Home or Almshouse, or on Blackwell's Island. It was an impressive occasion alike for crippled children, for general medical and surgical cases, for hopeless paralytics, for the blind, and for the old people at the almshouse. In every case they listened spellbound to the joyous carols, hardly ever applauding, for it seemed indeed a truly religious ceremony. After hymns had been sung near some of the crippled children, one of the sturdy little boy sopranos remarked huskily that it made something come in his throat to look at those children and he found it hard to sing. Perhaps nothing more incongruous could be imagined than the scene in the old men's day room at the almshouse, where, the air thick with tobacco smoke, several hundred old men sat, almost motionless, listening to "God Rest You, Merry Gentlemen." It was touching see one hat after another come off.

Christmas in the convalescent ward, women's psychopathic department, Philadelphia General Hospital

The hospital occupation committee, a sub-committee of the New York city visiting committee, had charge of the celebration at Bellevue Hospital. Through that committee five trained occupational therapy aides and four workshops have been maintained at Bellevue since 1920, and more than 3,000 patients have been taught each year. The occupational aides acted as mistresses of ceremonies in their respective wards. Christmas parties were held in nine wards. Trees decorated with colored lights and with gay colored ornaments made by the patients, as well as with balls and tinsel brought by the committee, were set up and trimmed on the Friday before Christmas by the aides, patients and visitors. Christmas greens fes-

Not a single Christmas green was disarranged by patients in the disturbed ward of the Middletown State Hospital, New York, although the elaborate decorations were allowed to remain for two weeks after Christmas. The photograph on the left shows the ward when the decorations first were put up; the view on the right was taken two weeks later.

tooned even the most dismal wards. Ice cream and cake was served to all, and in most cases individual presents were given to the patients in the nine different wards. Toys, puzzles, games, and books, as well as candy and fruit were provided for the children. The crowning event of the party was a concert given by a harpist and two singers, who went around to each of the nine wards, receiving an enthusiastic reception wherever they appeared. On Christmas Day, the choir from St. Bartholomew's Church sang in the corridors, and in many of the wards at Bellevue, giving great pleasure to the patients, staff and employes.

During Christmas week plans were made for music in Gouverneur, Harlem, Fordham, City, Kings County, and Kingston Avenue Hospitals. In all cases there were singers, accompanied by piano, harp, violin or cello. As a development of this Christmas music, a regular standing committee on music has been added to the New York city visiting committee. Through the secretary of this committee more than thirty concerts, vocal and instrumental, by tried musicians were given during the past summer at the various municipal institutions of the different boroughs.

Sea View Hospital

The following program will give an idea of how the Christmas season was spent at Sea View Hospital. The stockings distributed were made by the patients as occupational therapy. In that department the patients also colored 1,000 Christmas cards which were sent to the friends of the hospital.

Date	Time	Place	Event
Dec. 21	2 p. m.	Auditorium	Concert and vaudeville
	7 p. m.	Auditorium	Masque and civic dance for patients and employes
23	2 p. m.	Wards 13 & 14	Christmas trees and gifts
24	7 p. m.	Auditorium	Motion pictures
	3 p. m.	Building No. 1	Distribution of gifts
	3:30 p. m.	Farm Hall	Christmas tree
	5 p. m.	All Wards	Distribution of stockings
	6 p. m.	Women's Dormitory	Christmas tree
	6 p. m.	Infirmary	Christmas tree
	7 p. m.	Ward 33	Christmas tree and gifts
	7 p. m.	Ward 34	Christmas tree and gifts
	7 p. m.	Ward 43	Christmas tree and gifts
25	5 a. m.	Auditorium	High mass
	8 a. m.	Farm Hall	Low mass
	9 a. m.	Auditorium	Religious services for protestants and distribution of delicacies
	10:30 a. m.	Farm Hall	Religious services for protestants and distribution of delicacies
26	3 p. m.	Farm Hall	Entertainment
	7 p. m.	Cottages	Motion pictures
27	3 p. m.	Building No. 1	Concert and refreshments
	7 p. m.	Auditorium	Motion pictures
	7 p. m.	Farm Hall	Entertainment and distribution of delicacies
28	3 p. m.	Cottages	Ice cream party and entertainment
30	3 p. m.	Auditorium	Children's Christmas tree and party
	7 p. m.	Auditorium	Motion pictures

Ontario

In one of the military hospitals, the aides have an annual sale. Last year they raised $2,000 just before Christmas which was of great assistance to the men and their families. The occupational therapy department helps with the Christmas tree, concert and decorations.

Pennsylvania

Philadelphia General Hospital

Preparations begin weeks ahead of Christmas at Philadelphia General Hospital, for there are many trees to be decorated, about 110 of all sizes, some of them very large and none of them very small. Each ward has its tree which the patients help to decorate. Much prodigality is displayed in putting things on, sometimes where a wise restraint would be more effective, but the pleasure is often in proportion to the lavishness.

Gold and silver paper, tinsel, ribbon and all the other makings of gay and festive nothings are cut or otherwise prepared for easy handling and then taken hither and yon to the patients. Prescriptions are, to a great extent, dispensed with, as the work is so light and easy that the workers can use their own judgment about giving it to them. At first, perhaps just after Thanksgiving, little interest is displayed, but as time goes on (especially if Jack Frost cooperates by making the weather a bit sharp) enthusiasm waxes more keen and all the patients are eager to help. As the finished things come in we tie them in tens to facilitate the work of distribution on Christmas Eve, for all departments must have their proper proportion. Last year over 15,000 trifles were made and several hundred holders for the patients' candy. To see the patients here and there on a ward working on holly red crepe paper wreaths, silver tinsel ornaments or some other like trifles soon imparts a holiday flavor to life and sometimes even a very grouchy patient will catch the spirit and can be persuaded to do something. An attempt is made to have as many patients as possible making things for in this way a miracle is wrought. The Christmas tree decorations are made, but behold! in the making something of far more importance for a successful holiday season is developed—that subtle, undefinable thing, a Christmas spirit, chiefly compounded of love.

After everything is given out on Christmas Eve (with the exception of a few that are reserved in the background for the last tree or two) the aides go around to see the trees being decorated and make sure that everybody has enough and now the work of the occupational therapy de-

partment is completed. The pride which patients take in the trees is a beautiful thing to see. The whole hospital, wards, corridors and everywhere, has been decorated with ropes of laurel, and individual touches are added by further decoration in the different wards.

Last year a permanent community tree was planted, an enormous live evergreen tree, given as a beautiful memorial by a friend of the hospital and each year it will be lit up with numberless colored lights.

Christmas starts very early. Long before it is light the nurses go around to all the different departments singing carols. Later in the day Santa Claus visits all the children in the hospital. He has to be multiplied by four, in order to cover the ground; four of the interns fill the role. The adults are remembered with candy, fruit and presents. New clothes have been issued to the convalescents and the people, as well as the wards, have a festive appearance.

Washington, D. C.

St. Elizabeth's Hospital

The spirit of Christmas is in the air,
The spirit of Christmas is everywhere.

The truth of this little poem was proved by the way the occupational therapy department of St. Elizabeth's Hospital carried the spirit of Christmas into the woodwork and toy shop, where twenty-five to thirty men patients worked.

For days the two aides were shopping for the party, going to market in the snow and carrying out the baskets of fruit and gifts to the hospital. The shop was decorated with evergreens and gay colored paper and the toys which were made by the men were hung among the decorations. This gave a decided Christmas touch to the scene. The rough tables were covered with white and red paper, and other tables were arranged for the games. These games the men had made especially for this occasion and so they were given the added pleasure of anticipation. All enjoyed the afternoon and one patient who hitherto had been surly was completely won over, and afterwards was friendly and tractable. The doctor in charge attended and expressed his appreciation of the aides' efforts. The Red Cross furnished ice cream, cakes and apples, while the aides distributed the fruit, candy and gifts. The games were tossing quoits made of pasteboard, hot-potato, pining the donkey's tail, and going-to-Jerusalem.

The large work room in one of the women's buildings at St. Elizabeth's Hospital, where the weaving, sewing and embroidering of the occupational therapy department was carried on, was transformed at Christmas by decorations of evergreens and bright colored crepe paper streamers and tables were arranged for games and refreshments. The enthusiastic aides received fifty-five patients (some coming from the convalescent wards) and entertained them as their honored guests. In giving this pleasure their reward was the joy of helping to shed abroad, even into the confines of this institution, the spirit of Christmas.

Wisconsin

Muirdale Sanatorium

At Muirdale Sanatorium for the Treatment of Tuberculosis, at Wauwatosa, Christmas time belongs to the children, and with sixty or more little folks, ranging from babies to fourteen-year-olds in the children's cottage the grown-ups at Muirdale try to make Christmas a memorable time for them. Christmas trees and decorations are furnished for each solarium on the wards and in the cottages, the largest one being reserved for the dining room which serves as a recreation hall. The committees of the Welfare Club, the patients' organization, take charge of the decorations. In the children's cottage a facsimile fireplace is set up and a miniature scene of Bethlehem is laid out to make the Christmas background more real.

On Christmas Eve the children gave a program in the dining hall consisting of songs, poems and dialogues which they have learned along with their lessons at open-air school. The large tree is lighted and is rivaled by the sparkling eyes of the children who are wondering how many parcels Santa Claus will hand to them from the wonder-tree. After the program which is enjoyed equally by the participants and audience, Santa arrives, and the suspense is over. Each child receives two gifts from the county, with candy and fruit, on this night. All other presents are delivered by the relatives on visiting days; in this way all receive an equal share at the party. Each child may write to Santa with two requests which are granted, if possible. In addition to this new kiddie-cars and playroom equipment appear miraculously.

Christmas day special services are held in the chapel and in the afternoon open-house is allowed. Entertainers usually favor the patients in the afternoon; last year some children danced and sang, much to the delight of the little folks who felt that it was their own special treat. A real Christmas turkey dinner is served throughout the sanatorium and the holiday season at Muirdale lives in memory from year to year.

Columbia Hospital

Christmas 1921 was a happy gay time in the Columbia Hospital Curative Workshop, Milwaukee.

Fifteen crippled children, nearly all suffering from the effects of infantile paralysis, were entertained with their parents, brothers and sisters. Santa Claus had provided a large Christmas tree and had a bag on his back with presents for all. Doctors, nurses, convalescent patients from the hospital and guests filled the shop to its utmost capacity.

The boys had all written to Santa Claus for real watches and when the old saint pulled out watches for each one, the joy of the youngsters brought tears to many eyes. The girls had large cradles for their dolls.

The number of children has increased since last year, but it is hoped that they may be given as good a time as was provided on Christmas of 1921.

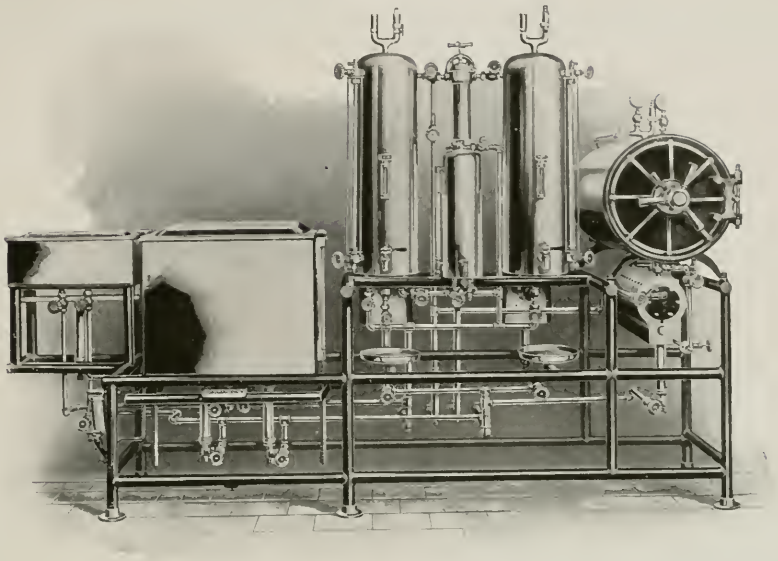
Children's Hospital

As Santa Claus arrived at Children's Hospital, Milwaukee, last Christmas he was greeted by the children singing: "Santa Claus please hurry up; we are all excited!" No words could express more truthfully the joyful expectancy with which the patients awaited their good friend who comes but once a year. And to please him they recited Christmas rhymes and sang Christmas carols.

John, a boy of fourteen, his club feet in casts for correction, was their leader. For weeks he had drilled the younger ones in recitations and has practiced Christmas music on his cornet. So on the great day he sat in their midst, his pompadour brushed until it shone, his red necktie most properly tied. His beautiful soprano voice led the chorus and his cornet solos were well rendered. The success of the program was due to his leadership.

Santa Claus, most appreciative of the patients' efforts, showered them up innumerable toys, and with empty bag left for the North Pole promising to return on schedule time in 1922.

"No one but the mother of it knows how precious an infant-idea becomes; nor how the soul dies between the destruction of one and the taking up of another."—Florence Nightingale.



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"They do look somewhat the same, Doctor, until you've used them—then you see a lot of difference. These Sterilizers, for example, provide for everything you need in sterilizing and they're so simple. The nurses don't make mistakes for they run them by rules which they really understand."

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Meetings, Conventions and Conferences

STANDARDIZATION IS THEME OF COLLEGE OF SURGEONS' OPENING SESSION

HOSPITAL standardization took up the entire first day's session of the Clinical Congress of the American College of Surgeons held in Boston, October 23-28. Sessions were held at Jordan Hall and consisted of a formal program of papers and reports in the morning and a helpful round table discussion in the afternoon.

At the morning session Dr. Franklin H. Martin, director-general of the College, reported on its standardization activities in 1922. For the first time this year a complete survey of the fifty-bed general hospitals was made, in addition to the larger institutions. Summarizing the growth of this movement since 1918 the following figures demonstrate the progressive improvement; 89 of the general hospitals having 100 or more beds met the standard in 1918; 198 in 1919; in 1920, 407 or 57 per cent; 1921, 579 or 76 per cent; this year 677 or 83 per cent of the 812 hundred bed general hospitals are on the approved list.* In addition there are 811 having a capacity of 50 to 100 beds of which 335 or 41 per cent were approved this year. Dr. Martin also made public announcement of aid received from the Carnegie Foundation in assisting the financing of the hospital standardization program.

Mutual Obligations of Doctor and Hospital

Dr. Frederic A. Washburn, superintendent of the Massachusetts General Hospital, Boston, discussed, "The Doctor and the Hospital" in an interesting paper. He divided his address into two parts: first, the hospital's obligation to the doctor; and second, the doctor's obligation to the hospital. Relative to the former he emphasized the fact that the hospital should treat its staff with due consideration; that it should share with practitioners, in general, the advantages of its resources; visiting physicians and physicians referring patients should be furnished with every courtesy; medical students and interns should receive the highest type of training; the hospital should be able to treat all types of patients irrespective of their means.

On the other hand the physicians should cooperate with the administrative staff and with their fellow staff members, since team work rather than individual accomplishes the best results. Staff members should devote an adequate amount of time to the hospital. Dr. Washburn also stressed the importance of the family physician aiding the hospital in obtaining autopsies.

*The list of approved hospitals was published in the November issue of The Modern Hospital.

Dr. Frederick W. Slobe, in charge of the hospital standardization department of the College, discussed "The Minimum Standard and Its Application to Hospitals." He mentioned certain difficulties which hospitals meet in their endeavor to meet the minimum standard. The hospital is the logical repository for the medical records of the community as the records kept in the physicians' offices are too variable to obtain accurate information in many instances. Owing to the insufficient supply of interns to meet the demand, the use of trained record-clerks is essential. Physicians can dictate their findings to these clerks. Careful supervision of the records by each staff member is necessary in order for the records to be accurate and complete. Relative to staff organization, it is for each hospital to decide what type of organization will meet its local needs. A careful analysis of end-results, particularly the casualties of each month, should be undertaken. Staff meetings should be held at intervals of not more than one month. The extent to which laboratories are used is due largely to the system of laboratory charges employed. The flat-rate fee was said to remedy this difficulty. The need for a greater quantity of routine tests including a routine examination of each tissue removed in the operating room was emphasized.

Father Moulinier Outlines Benefits

The Rev. C. B. Moulinier, S.J., president of the Catholic Hospital Association, chose as his subject, "What Real and Lasting Benefit Has Come to the Patient From Hospital Standardization." He emphasized the importance of coordination of effort among medical, nursing, and hospital people, as produced by the standardization program. As a result better diagnosis, more careful treatment, and safer surgery are produced. The Rev. Fr. Moulinier made a strong plea for increased cooperation among the physicians. Each physician should feel an individual responsibility in guaranteeing the hospital complete and accurate records of his patients.

Dr. A. R. Warner, executive secretary of the American Hospital Association, spoke on "The American Hospital." He stated that the American hospital is now in the process of finding out its many responsibilities involved in the professional care of its patients. Many court decisions have brought out this fact. The decisions are based on two points: first, that the hospital must be just before it is generous; and, second, that care must be exercised in the selection of its agents. Recent decisions are

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Promoting a Favorable State of Mind

On the borderland of illness or convalescence, patients frequently tend towards a morbid state of mind.

The usual habits of active life perhaps have been, or must be suspended. Daily existence seems one negation after another. And most irksome of all is the restricted diet.

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neglecting any consideration of factors such as whether the patient is free, part-pay, or full-pay, or whether ward or private. The inherent right of a hospital to appoint its staff and to decide who may or may not treat patients within it was emphasized.

Dr. D. A. Craig, provincial commissioner of the Nova Scotia Division, Canadian Red Cross, Halifax, spoke on "Hospital Standardization From a Public Health Standpoint." He states that the basic principle of public health is the prolonging of human life and human efficiency. Hence, public health work must be in close cooperation with the medical profession and the hospital. Each physician and hospital likewise should assist in public health activities. A slogan employed by Dr. Craig was: "Our hospitals owe future generations records of present experiences." The hospital standardization program is a wonderful opportunity for public service.

Dr. Robert Jolly, superintendent of the Baptist Hospital, Houston, emphasized the assistance which the standardization program of the College gives hospital superintendents in their efforts to obtain increased hospital facilities; the assistance which it gives to physicians in their endeavor to obtain better results; the assistance it gives to the board of directors in keeping them in close touch with activities in the hospital. Improved team work, complete organization, and analysis of hospital results are thus obtained.

Laxity in Determining End Results

"The Analysis of End-results" was discussed jointly by Dr. Eugene H. Pool, New York, and Dr. E. A. Codman, Boston. Dr. Pool discussed the methods used in the New York Hospital to secure information as to their final results. From follow-up studies the surgeon gains a knowledge of the results of his operative work and has an opportunity to check his original diagnosis. Sufficient clerical help, a card index system, social service department and follow-up clinic are essential to carry out this program.

Dr. Codman divided the hospitals into two groups, those which care to make an effort to find out what results they are getting and those which do not. Many hospitals which have instituted the requirements of the standardization program are lax in their efforts to determine their end-results. In order to accomplish this each physician must openly express a frank desire to learn the truth concerning his results. The board of directors must be thoroughly cognizant of the hospital's activities and of its staff members. Those who have responsibility in the hospital should exercise their authority by a close scrutiny of all the activities of the hospital so that the future may profit by experience of the past.

Dr. Malcolm T. MacEachern, president-elect of the American Hospital Association, in summarizing hospital standardization, presented an interesting set of lantern slides portraying the actual operation of the standardization program in hospitals. He pointed out that the fact that through staff organization there was a careful check-up on the professional work of the hospital, thus stimulating more careful work. Difficult problems are solved in the monthly conferences and the increased cooperation resulting stimulates such individuals to increased efforts. It has been proved conclusively that hospital standardization means a shorter stay in the hospital for the patients, few complications, infections and deaths. He presented a monthly balance sheet which furnishes the board of directors an accurate idea of the activities and results in the hospital during each preceding month.

Round Table Is Profitable

Round table discussion was most stimulating.

The discussion of staff organization was led by Dr. Frank D. Jennings of Brooklyn.

Dr. George A. Ramsey and Dr. Roy C. Kingswood of London, Ontario, introduced the topic of case records. The discussion concerned itself with medical case records, the best methods of securing records in various types of hospitals, methods that can be adopted to stimulate increased interest in record keeping, the value of a historian or record clerk where there are no interns, and the advantages of an up-to-date case record system to the hospital.

Dr. John F. Bresnahan, superintendent of Bridgeport Hospital, Bridgeport, Conn., directed the discussion of clinical laboratories. What constitutes a complete x-ray service was discussed under the chairmanship of Dr. William A. LaField, roentgenologist at the Bridgeport Hospital, Bridgeport, Conn.

Miscellaneous discussion regarding a variety of questions concerning hospital standardization was led by Drs. E. Murray Butler and A. R. Warner of Chicago.

PUBLIC HEALTH WORKERS HOLD 51ST ANNUAL CONFERENCE

The fifty-first annual meeting of the American Public Health Association, held in Cleveland, October 16-19, was notable first of all from the fact that the aims and policies of the organization were fundamentally defined and clarified so as to make it primarily a professional organization of trained sanitarians. The development and standardization of the public health profession constitute one problem; the mobilization of popular support for the public health campaign is another.

The feeling that attention divided between these two problems was leading nowhere led at the New York meeting a year ago to the appointment of a Committee on Re-organization with Henry F. Vaughan, health officer of Detroit, as chairman. This committee recommended at Cleveland that "the objectives of the association should be the preparation, study, standardization, and presentation of scientific public health procedures, and the best method by which such knowledge can be given to the public, and the expression to the public of professional opinion in regard to such procedures."

In order to maintain the authoritative position of the association the by-laws were changed so as to differentiate between associate members (persons interested in public health), members (persons active in the service of public health), and fellows (professional health workers of at least two years standing as members of the association, and of established professional standing—whether employed by public or private agencies or in independent private practice).

Dr. E. C. Levy, director of public welfare of Richmond, Va., was unanimously elected president for the term 1922-1923. The other officers chosen are as follows: first vice-president, Henry F. Vaughan, D.P.H., commissioner of health, Detroit, Mich.; second vice-president, Gabriel M. Malda, M.D., director of the national department of health, Mexico; third vice-president, H. L. Rockwood, M.D., health commissioner of Cleveland, Ohio; executive secretary, A. W. Hedrich, New York; treasurer, Roger I. Lee, M.D., Harvard University, Cambridge, Mass.

Members of the executive board, elected were as follows: L. K. Frankel, Ph.D., Metropolitan Life Insurance Company, New York; Charles J. Hastings, M.D., health officer, Toronto, Canada; A. J. McLaughlin, M.D., assistant

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surgeon general, U. S. P. H. S., New York; M. P. Ravenel, M.D., professor of public health, University of Missiouri; Henry F. Vaughan, D.P.H., commissioner of health, Detroit, Mich.; C.-E. A. Winslow, D. P.H., professor of public health, Yale School of Medicine, New Haven, Conn.

The association adopted resolutions in commemoration of the life and work of Pasteur; in favor of more adequate teaching of public health in medical schools and in elementary schools; a resolution recording "its conviction that experiments on living animals have proved of the utmost service to the public health in the past, and therefore to civilization, and are indispensable to future progress" and therefore opposing H. R. 12605; and a resolution stating that "there should be but one standard of fitness for all who desire to practice the healing art and but one channel through which persons desiring to practice that art may obtain licenses so to do." Committees were authorized on the defense of research, on public health education in medical schools, on health education in the common schools, and on the incidence and control of pneumonia.

KANSAS ASSOCIATION CONDUCTS WORTH WHILE ANNUAL PROGRAM

THE eighth annual meeting of the Kansas Hospital Association was held at the Carnegie Library Hall at McPherson, October 11. It was a very profitable and interesting meeting and every minute of the time was occupied to good advantage.

The annual financial statement and the minutes of the previous annual meeting at Newton and the special meeting at Topeka were read by the secretary, Dr. J. T. Axtell, and approved as read.

Dr. Axtell explained that the meeting at Topeka had been called by President Hatcher because of an order sent out to each county by the state tax commission placing all hospital property, except that of municipal and county hospitals, on the tax rolls. A large number of the members of the Kansas Hospital Association attended this meeting at Topeka on April 17. Senator L. H. Finney of Wellington, Kan., was employed to represent the hospitals. The members met at the National Hotel and there was a general discussion of the subject.

Win Fight for Tax Exemption

The fact was brought out that the state board of administration has the power in Kansas to designate which hospitals are charity hospitals and which are not. The hospitals designated by it as charity hospitals, even though they may have pay patients, are given a small donation from the hospital fund appropriated by the state legislature. It has been the custom of the state tax commission to exempt from taxation hospitals recognized by the state board of administration as charity hospitals. A committee was appointed to meet the state board of administration in the afternoon, when the claims of the different hospitals were presented. The board took the matter under advisement, and in a few days issued an order to county assessors to take all church hospitals off the tax rolls. Soon expert accountants were sent out over the state, who very rigidly and thoroughly examined the books of the other hospitals and those who were found to be doing sufficient charity work were given a small donation and were exempted from taxation by the state tax commission.

This was one of the most important pieces of work accomplished by the association during the year and just such an emergency as this proves the value of an organization of this kind and what can be accomplished by united effort.

President Lauds Standardization Program

Dr. A. R. Hatcher gave his president's address, in which he made many practical suggestions for work that the association might take up during the coming year. He stated that there are 101 hospitals in Kansas, including Santa Fe hospitals, state institutions, etc., with a capacity of 8,331 beds. From this it was seen that not a large enough proportion of the hospitals are enrolled as members of the state association and plans were discussed whereby the membership might be increased. He also discussed the taxation problem, saying that there were no purely charitable hospitals in the state, as all receive some pay patients, and that unless this matter were permanently settled, it would probably come up again in the future. He recommended that a legislative committee be appointed to work out some legislation on the matter. The standardization of hospitals has done much to revolutionize hospital work and the class of service rendered. As the hospital stands for service in a community, the care of the sick being its purpose and most important function, anything and everything that will tend to improve the class of service rendered is worthy of serious consideration, in his opinion.

Dr. W. C. Heaston of McPherson presented an interesting paper on the "County Hospital; Its Growth and Possibilities," in which he gave a brief history of hospital conditions in McPherson County and the procedure followed in getting that county to vote bonds to build and equip the splendid McPherson County Hospital which they now have. This paper was freely discussed and comparisons made as to whether these same plans might be practical in other counties.

Luncheon for Delegates

The members enjoyed luncheon together and the meeting was again called to order at 1.30 p. m. Dr. Charles E. Ross of Wichita gave an especially well prepared paper on "Encephalitis and Some of Its Sequels." The article showed experience and long research on the part of Dr. Ross in this line, in which he is a specialist.

"Hospital Nursing" was the title of a paper read by Miss Corrine Mittong, superintendents of nurses at Axtell Hospital, Newton, Kan. In this she brought out the importance of well trained nurses, their relation to the doctors and the hospitals, and the wide scope of education possible in a good training school.

Round table discussion was then conducted under the leadership of Dr. J. T. Axtell. The members handed in questions which were taken up and freely discussed. In the discussion pertaining to the time required in the various training schools—two years, two and one-half years, and three years—it seemed to be the consensus of opinion that the standard should not be lowered, and the three year course was approved. Also, the majority seemed to favor a closed staff for hospitals, on account of thus being

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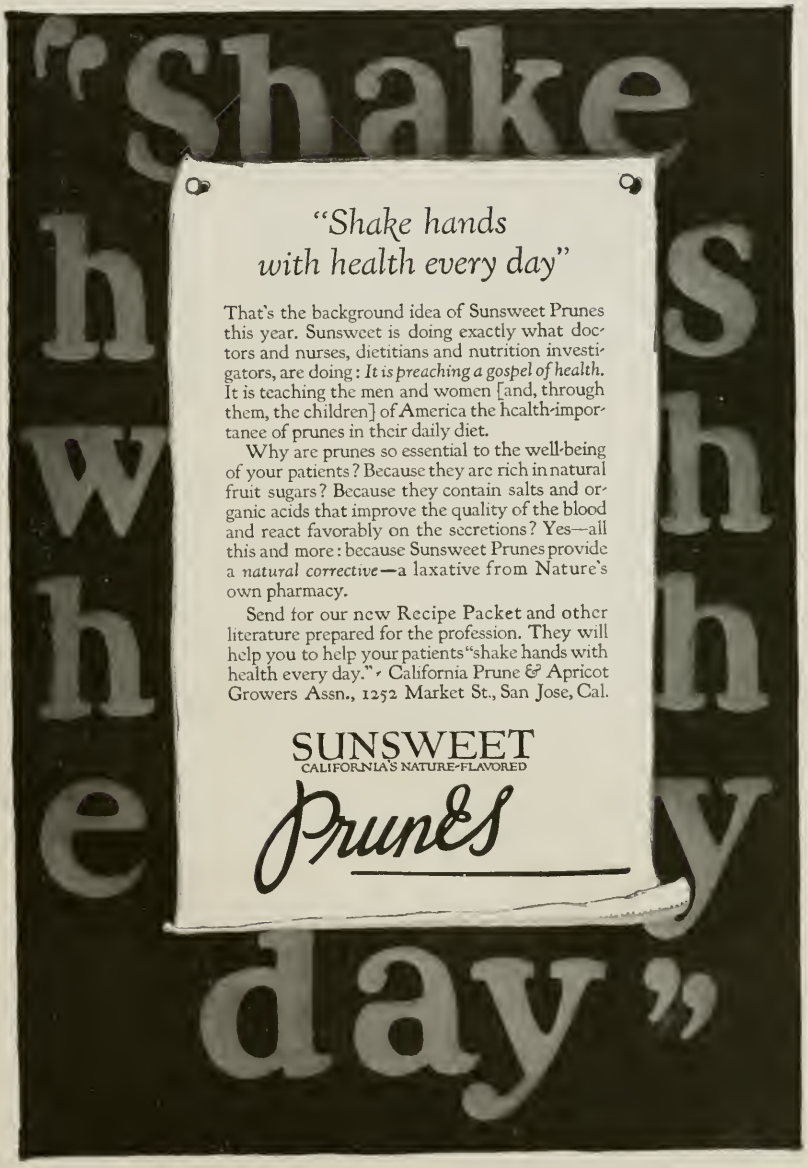

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able to secure more uniform and better kept records. The prevailing rates for rooms and nursing, the plans of operating x-ray and laboratory departments, business administration, and methods of financing hospitals, were all freely discussed.

In the election of officers for the year it was decided to follow the plan of the American Hospital Association and elect a president to take the chair at the time of the annual meeting in 1923. It was voted to reelect Dr. A. R. Hatcher of Wellington, as president for the ensuing year; and Mr. S. G. Ascher, superintendent of the Wichita Hospital, Wichita, Kan., was elected president-elect to assume the office at the next annual meeting. Mr. Ascher has had many years of hospital experience, principally in the larger Eastern cities, and will make a valuable and efficient president. Miss Dena Gronewald, superintendent of McPherson County Hospital, was elected vice president. Dr. J. T. Axtell of Newton was re-elected secretary-treasurer. The next annual meeting will be at Wichita in October, 1923, the exact date to be set later by the executive committee.

After the meeting adjourned the members were invited to visit the McPherson County Hospital, where they were shown through the entire building by Dr. L. F. Quantius and the superintendent Miss Gronewald. The facilities of this modern hospital are of the very best.

SASKATCHEWAN HOSPITAL WORKERS CONVENE AT MOOSE JAW

THE fourth annual convention of the Saskatchewan Hospital Association was held in Moose Jaw, October 11-12. Delegates to the number of thirty-nine, representing twenty-three hospitals in the province, were registered. Mayor W. F. Dunn welcomed the delegates on behalf of the city.

The chairman, Mr. Joseph Needham of Unity, after addressing a few remarks to the assembly, called on the first speaker, Miss E. M. Thompson, instructress at the Regina General Hospital, who gave a very interesting and instructive paper on "The Training of Nurses in School and Practical Work." Considerable discussion was provoked by the paper.

Describes Work at Mental Hospital

A clear and carefully studied paper on "The Mentally Deficient and Their Care and Treatment" was given by Dr. R. M. Mitchell of Weyburn Mental Hospital. In opening his remarks, Dr. Mitchell said that his address would be on the work that is actually being done in the Weyburn Mental Hospital, and said that the textbooks on the work were of little practical use.

Patients in the hospital were classified by him in four groups: the idiot, incapable of even caring for himself; the imbecile, with a mentality that can be developed to that of a child of three; the feeble-minded, whose range of mentality is limited to 11 years of age; and the moron, who is normal in many respects. From the last-named class, continued the doctor, exhaustive tests has proved that 95 per cent of the inmates of jails and penitentiaries are drawn.

Most of the instruction in the Weyburn Hospital schools, said Dr. Mitchell, is along manual, rather than academic lines, for the patient can be instructed to use his hands.

In conclusion, the doctor said that he would like to arrange for an exchange of nurses in training for periods of from six months to a year, so that general hospital nurses could be taught to care for the mentally deficient.

Presentation of the report of Nurses' Education Committee of the Saskatchewan Registered Nurses' Association was given in the course of the morning session by Miss E. M. Turner, R.N., superintendent of nurses, Saskatoon City Hospital.

Immediately after lunch on the first day, the delegates were driven by the local doctors to the Providence Hospital on the invitation of the Sister Superior to inspect a demonstration on dietetics in the way of food values.

On resuming the session at 2.30 p. m. a report on "The Training of the Nursing Housekeeper" was submitted by Miss Mabel F. Gray, R.N., who is in charge of this work. It was brought out in the discussion that if these young ladies who are training for this work would remain in the country communities where other nurses are not available, they would be filling a very felt need.

An address by Mr. W. F. Marshall, field secretary of the Canadian Red Cross Society for Northern Saskatchewan, closed the afternoon session, after which all the delegates proceeded to the nurses' home of the General Hospital, where they were entertained at tea by the staff and pupil nurses of that institution.

The sessions for the second day were opened by an excellent "Review of the Hospital Situation in Saskatchewan for the Past Year," given by Dr. F. C. Middleton of the government bureau of public health.

"Our province has reason to be proud of the efforts being put forward by the people in trying to furnish hospital accommodation," Dr. Middleton declared. "It is a pleasure to note that most of our hospitals are endeavoring to fulfill the requirement as outlined by the editor of THE MODERN HOSPITAL, in his definition of a modern hospital, as follows: 'A modern hospital is an institution whose objects are the care and treatment of physical and mental illness and injury; the education of patients in hygiene, both personal and public; the clinical training of doctors, nurses and hospital social service workers; the advance of medical science and the prevention of disease.'"

Urges Two New Sanatoriums

An address was given by Dr. R. G. Ferguson on "The Care and Treatment of Tuberculosis." Dr. Ferguson dealt with the dread nature of this disease, which he said was perhaps the greatest in this country apart from that of social vice. He pointed out that the sanatorium at Fort Qu'Appelle is filled to overflowing and there is a very urgent need for the construction of other two such institutions in our cities. These, he believes, would be of more value than in country points, owing to the fact that patients and their friends could reach them in a much more expeditious manner. He further pointed out that the only way to stamp out this disease is by educating the public and by the careful inspection of all school children by doctors and nurses. He also suggested the annual examination of every adult of our population. He then spoke of the possibility of affiliation of nurses of training schools of the province with his institution, so that these young women might go out more fully equipped

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in the matter of handling patients who have tuberculosis.

The remainder of the morning was taken up by a round table discussion, led by Mr. A. Wilson of Prince Albert Municipal Hospital. This was very much appreciated and appeared to be one of the most popular parts of the convention, insomuch as it offered an opportunity for all the delegates to meet in a friendly discussion of the problems which confront them; in many cases solutions were found.

During the second day the delegates were entertained at lunch by the board of governors of Moose Jaw General Hospital, presided over by the Venerable Arch-Deacon Wells Johnston, chairman of Moose Jaw Hospital board, at which several entertaining speeches were made and a vote of thanks tendered to the board of directors for its courtesy.

The whole of the afternoon was given over to the presentation of reports and the consideration of resolutions, which a committee was instructed to take before the government at Regina, with a view to having certain parts of the Hospital Act amended. The election of officers also formed part of the session, and the following were named for 1923:

Honorary president, Hon. C. A. Dunning, Premier, Regina.

Vice president, Mr. Joseph Needham, Unity.

Secretary-treasurer, Mr. T. T. Murray, Saskatoon.

The next convention is to take place at Prince Albert between June 15 and July 15, 1923.

HOSPITAL WORKERS AND NURSES OF ALBERTA MEET IN JOINT CONFERENCE

THE Alberta Hospital Association and the Alberta Association of Registered Nurses met in conjoint convention at Edmonton on September 3. The following hospital, institutions and organizations were represented by delegates: Lethbridge, Galt, Calgary General, Holy Cross, Drumheller, High River, Royal Alexandra, Edmonton, Buelah Home and Lamont hospitals; the College of Physicians and Surgeons; the Society for the Prevention of Tuberculosis; the Alberta Medical Association; and the Alberta Nurses' Association.

Officers named by the convention for 1923 include: Honorary president, R. G. Reid, minister of health of the province of Alberta; president, Rev. Fr. Cameron, Holy Cross Hospital board, Calgary; vice president, H. B. Stickney, Drumheller Hospital, Drumheller; and secretary-treasurer, Mr. Williams, Drumheller Hospital, Drumheller.

The new executive committee is composed of the following members: Miss McLeod, High River; Dr. H. R. Smith, secretary, Royal Alexandra Hospital, Edmonton; Dr. Stanley, Calgary; Miss L. M. Edy, superintendent of nurses, General Hospital, Calgary; and E. E. Dutton, secretary, Galt Hospital, Lethbridge.

Resolutions covering a variety of hospital problems were referred to the association's special committee on legislation that it may bring the measures before the provincial government.

Important Resolutions Passed

Among them are:

Legislation which will allow cities to keep in suitable homes within their own territory aged and incurable persons, the provincial government to make grants for such cases as are allowed for hospitals now receiving grants. This is expected to be only a temporary measure until such time as the government or the municipalities can make more satisfactory provision.

Repeal of certain amendments which will enable hospitals to collect payment of regular hospital fees from municipalities for any patient who is a bona fida resident of such municipalities.

Suitable remuneration from the government to allow hospitals to maintain satisfactory training schools for nurses.

Grants to hospitals for the care of crippled children.

Altering of existing legislation to allow hospitals after they have exhausted all reasonable means of collection of accounts from ratepayers, to collect such accounts from the municipality, and further to collect accounts from those who are not ratepayers in any city from the provincial government at a stated rate per diem.

This final resolution also contains a suggestion to the provincial government that a health tax be levied; a recommendation that the government appoint an inspector of accounts for hospitals having city and government aid; and an appeal to the Workmen's Compensation Board to revise its schedule of hospital fees so as to make the minimum fee conform to the actual cost per patient per day.

Consider Problems of Hospital Economy

One of the valuable papers of the convention was that presented by S. V. Davis, secretary-treasurer of Royal Alexandra Hospital, on "The Problems of a Secretary-Treasurer," which opened the program proper, following a brief sketch of the work of the Beulah Rescue Home by Mrs. Mary A. Finley.

Mr. Davis told of the success of the "pay-as-you-enter system" in the collection of patients' fees. Economies in the purchasing of supplies and in the hospital laundry were emphasized.

W. T. Henry, chairman of the Edmonton Hospital board, gave an interesting paper on "Hospital Finance" in which he brought out the fact that a combination of the two systems of hospital finance—private donations and public funds—is the ideal system in hospital development. In this way the public interest is maintained by private contributions and the permanency of financial arrangements is assured by municipal support. It will not be long, he said, before all hospital effort in Alberta, except that provided by religious denominations, will be state-owned and state-controlled.

Mr. Williams of Drumheller conducted a round table which broke up the afternoon's program of formal papers. Before taking up the suggested questions, Mr. Williams in an introductory statement advocated that establishment of a taxation zone with the hospital as the center. Thus people living ten miles from a hospital would be charged a higher tax rate than those living twenty miles away. He favors a poll tax for hospital support, just as the people of the province are taxed $4 annually for the support of the schools. Such a system is already in partial operation in Mr. Williams' district and warm discussion centered around it. Most of

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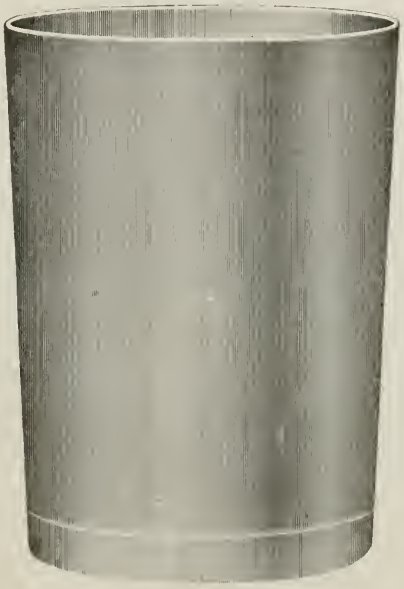

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the round table exchanges were based on this general topic.

"The Training School for Nurses" was discussed in a forceful paper by Miss Francis Macmillan, superintendent of the training school at Royal Alexandra Hospital.

"Too few hospitals offer their students a responsible home life with normal opportunities for relaxation and recreation," Miss Macmillan declared. "A patient requires around 1,330 cubic feet of air space in order to live under healthy conditions, yet some pupil nurses in Alberta are permitted to rest, study, sleep and keep most of their personal belongings in less than half that space.

"I am afraid that some of our living quarters for nurses would hardly stand the inspection of a public health officer, yet at the completion of their training some of our pupils are asked to teach public health in various parts of the province."

Following Miss Macmillan's address, the minister of health of Alberta, the Hon. R. G. Reid, spoke briefly before the convention welcoming its members and assuring them of the cooperation of the Municipal Hospital Department.

Educational Function of Sanatorium

Some phases of tuberculosis sanatorium work in the province were treated by Dr. Baker of the Central Alberta Sanatorium in a well-prepared paper. The primary importance of the sanatorium in the anti-tuberculosis movement lies in its value as an educational influence in health matters, he declared. A daily practical demonstration is given patients at his sanatorium of the ordinary sanitary requirements of houses in regard to heat and ventilation. Emphasis is laid on cleanliness of person, clothing and living quarters.

Definite training is necessary in methods to prevent spread of infection, Dr. Baker pointed out. Suitable pressure is often required to develop careful habits and this class of patients must be constantly watched; this is impossible unless he is in an institution or under the care of a trained attendant. In the Central Alberta Sanatorium, in addition to frequent individual instruction, the medical staff gives periodic talks to groups of patients. The result of such educational work is that nearly every patient becomes more intelligent, reasonable and conscientious in his endeavor to get well and to be as useful as possible.

Dr. Baker further stressed the fact that student nurses should be given experience in tuberculosis work by serving a few months in a sanatorium. In addition to its educational work and the care of the sick, the sanatorium should function as a center for the diagnosis of respiratory diseases. To this end it should be equipped with every known aid in diagnosis and staffed with those capable of giving the public the advantage of the most recent development in this branch of medical science.

"The Value of the Diet Kitchen to a Hospital" was made the subject of a paper by Miss H. Hunt who set out to convince her audience that the diet kitchen in the hospital is neither "an expensive luxury or a necessary evil." The profit to the nurse in training of diet kitchen experience, the advantage of the diet kitchen as a center of food control, and its value as a food laboratory were the three points developed by Miss Hunt.

The Rev. Fr. Cameron presided over the public meeting in the evening, at which brief talks were given by a representative of Mayor Duggan of Edmonton, the minister of health, and Dr. F. W. Stockton of Calgary. Some musical numbers also were given.

Dr. Archer of Lamont, representing the Alberta Medical Association, discussed the medical problems of moment in the province today, and Dr. Stanley, in a well-prepared paper, talked of the nurse and the hospital in relation to scientific medicine.

"If the physician, the nurse and the hospital are unquestionable factors in scientific medicine," said Dr. Stanley, "then in all fairness the hospital should be available to all citizens on fair and equitable terms. This it can never be until we have a provincial system which shall place at the disposal of every citizen the hospitals of the province. I do not necessarily mean that all must be municipal hospitals but I do mean this, that the provincial department of health should take such control over the administration of hospitals that it will be able to administer and classify them so as to provide for any one particular local district and for the province as a whole. This will mean a health tax."

MICHIGAN WORKERS TO MEET IN DETROIT

A tentative program of the Michigan Hospital Association, which will hold its annual meeting in Detroit, December 6-7, has been issued by the secretary, Dr. Stewart Hamilton. The sessions will be held in McLaughlin Hall, the nurses' residence of Harper Hospital.

Among the papers to be read are the following:

"Should the Patient Exist for the Hospital, or the Hospital for the Patient?" by Miss Grace McElderry, Hackley Hospital, Muskegon.

"The Hospital Intern—Methods of Securing Well-Trained Men and Means of Providing Them with Valuable Instruction," by Dr. C. W. Munger, Blodgett Memorial Hospital, Grand Rapids.

"The Hospital as an Educational Center," by Dr. Charles E. Stewart, Battle Creek Sanitarium.

"Civil Rehabilitation," by Mr. Percy Angove, state supervisor of vocational rehabilitation.

"The Emergency Problem in the Hospital," by Dr. T. M. Gruber, Receiving Hospital, Detroit.

"The Relation of the Technical High School to the Hospital Training School," by Miss Helen Livingstone, Cass Technical High School, Detroit.

Fifty-Year Internships as Required by the Michigan State Board of Registration," by Dr. C. G. Parnall, University Hospital, Ann Arbor.

"Social Service Problems in the Hospital," by Miss Alice Walker, Harper Hospital, Detroit.

"Deep X-ray Therapy in Relation to the Hospital" by Dr. W. A. Evans, Harper Hospital, Detroit.

NORTH CAROLINA ASSOCIATION MEETS

The annual meeting of the North Carolina Hospital Association was held at Wilson on November 2. The papers showed careful preparation and the round table discussion, conducted by Dr. Hubert Royster, proved lively and informative. Among the papers read were:

"Financial Problems of an Average Hospital," by Dr. J. T. Burrus of High Point; "Problems of Training Schools for Nurses," by Miss E. A. Kelly of Highsmith Hospital; "The Present Status of North Carolina Hospital Training Schools," by Miss Edith M. Redwine; "What an 'A' Grade Medical Hospital Would Mean to Humanity in North Carolina," by Dr. Otho B. Ross of Charlotte; "How a Hospital Can Have Proper Laboratory Facilities," by Dr. Harvey P. Barrett; "How a Municipality or County Should Assist a Local Hospital," by Dr. J. M. Parrott of Kingston; "Hospital Administration," by Dr. C. D. Hill of Watts Hospital.

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LETTERS TO THE EDITOR

NURSES' HOMES, PRESENT AND FUTURE

To the Editor of THE MODERN HOSPITAL:

This communication was prompted by a recent letter of inquiry which introduces a topic of general interest and importance, and which reads as follows:

"We have a fund for the erection of a new nurses' home, but hardly know how to use it, because we are troubled by the fundamental question of the character of our future nursing organization. It would be comparatively simple to provide accommodations for pupil nurses, instructors, and supervisors; but it seems that some of the leading hospitals are now employing considerable numbers of attendants or nurses' assistants of a quite different social and professional class. Should dormitory space be reserved for this class in our nurses' home?"

While there is a unmistakable drift toward the employment of half-trained bedside attendants, no one can say precisely how long or with what force the current will continue to flow in its present direction; but, barring a turn of the tide, the present drift seems likely to bring about revolutionary changes in the nursing organization of the hospitals.

The employment of sub-nurses, whether under the name of attendants, nurses' assistants, or ward maids, is an expedient to which many hospitals, faced with a shortage of student nurses of a higher grade, resorted long before state boards undertook to define the education and duties of attendants. An inquiry recently addressed to thirty prominent hospitals showed that twenty-nine were employing or were contemplating the employment of attendants; and it is significant that the employment of attendants was no longer being resorted to as a temporary measure.

Attendants in hospitals are causing a great deal of embarrassment, because suitable quarters are not available for them. To ask the attendant to share the quarters of the domestic worker is to put her socially in the class of the domestic worker, which means that in the long run the position of attendant will not appeal to women who are the intellectual superiors of the domestic servant. Nobody wishes to assign to such a group any large share in the care of the sick. In many instances the only practicable alternative is to permit the attendant to share the home of the pupil nurse, but this involves social contacts which certainly are not agreeable to either undergraduate or graduate nurse, nor particularly comfortable for the attendant.

The plans of a hospital not yet built, but which has strong financial support and which hopes to establish for itself a place of honor in the hospital field, show side by side buildings of almost equal capacity, one of which is marked "nurses home" and the other "attendants' home" (the fact that a waggish draftsman has written under the official designation "attendants' home" the words "Sairey Camp Hall," does not detract from the practical importance of this first official recognition, in major hospital planning, of a revolutionary change in the nursing program). What this new hospital is about to do suggests a precedent which may wisely be followed. Just how to proportion the two sets of dormitories, etc. is a question, because use of attendants varies in different parts of the country, and even in neighboring hospitals in the same community whose requirements and policies differ.

Thus far, for the most part, the attendant has been introduced into the hospital family because of the need of an extra pair of hands at the bedside; but two other motives come into play in the development of the new system. The first of these motives is a desire to save the pupil nurse from drudgery, or from the mere repetition of simple tasks which add little or nothing to her vocational training. This motive has induced some hospitals to employ attendants in the face of a plentiful supply of probationers. The second motive (to which I refer with bated breath) is that here and there staff doctors profess to find in the attendant a willingness to be helpful which is wanting or waning among pupil nurses. I have not personally observed any such tendency among pupil nurses, and yet the fact that many young women nowadays enter schools of nursing without the slightest intention of embracing bedside nursing as a permanent calling, gives color to the claim of those who argue that pupil nurses are not as interested as they used to be in the care of the sick.

When the members of the spring graduating class of a well-organized school of nursing, with liberal educational traditions, were questioned about their professional intentions, only one-sixth of the group spoke of undertaking private duty nursing. An almost equal number expressed a preference for institutional work (meaning thereby the supervision or instruction of those who care for the sick), while the remaining majority had in mind tasks varying all the way from hospital social service work to straight office work—tasks in some of which nursing elements were present, but in which the characteristic common element was that freedom which is the universal demand of young people today, and which embraces free evenings, free Sundays, free holidays, freedom to come and go generally, and a great range of human contacts and experiences—anything but close confinement to a sick room. The opportunity to achieve one's moral salvation by self-sacrificing devotion, which used to be the central theme of speakers at nurses' graduation exercises, was not conspicuously in the minds of this group.

One is tempted to digress for a moment to remark that while all doctors preach to nurses the ideal of self-sacrificing devotion, it is only that rare bird, the old-fashioned family doctor, who holds fast to this ideal in his

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own professional life. Comparable to the attitude of the typical pupil nurse of the day is that of the undergraduate medical student. I hazard the guess that two-thirds of the young men who are enrolled in our medical schools today have already turned their backs, figuratively speaking, on general practice, and that these men want to become specialists for exactly the same reasons that are causing undergraduate nurses to turn away from private duty nursing.

I have said that a majority of the members of the spring graduating class of a certain school of nursing were determined to avoid private duty nursing. To complete the picture, I should add that seventy per cent of the spring probationers were sure *before they began their training* that they would not eventually take up bedside nursing.

The indications point clearly to the gradual translation of the bulk of the nursing body to spheres of activity more or less removed from the bedside. It is not that nurses are being thrust out, that the cheaper currency is driving out the dearer, according to a sort of economic law. On the contrary, nurses are willingly relinquishing their accustomed duties and responsibilities with their eyes wide open; they are seeking freedom, independence, more varied activities, a higher professional status; they have grown tired of the grind of bedside nursing, and are glad to be relieved of the privilege of obeying the orders of doctors and of responding to the needs and whims of the sick. Under these circumstances, no hospital plan can be regarded as a wise one which does not include some suitable provision for the housing of attendants. For the hospital which is just beginning its work, and which expects to grow, a flexible plan which allows for the indefinite extension of both the nurses' home and the attendants' home is desirable.

S. S. GOLDWATER, M.D.,
Director, Mount Sinai Hospital, New York, N. Y.

USE OF SODA ASH IN LAUNDRY

To the Editor of THE MODERN HOSPITAL:

My interest in the hospital field, and my realization of the value that the hospital field places upon information given in THE MODERN HOSPITAL prompts me to comment adversely on the material used on pages 69 and 70 of the third issue of the YEAR BOOK. I refer particularly to the paragraph headed "The Choice of an Alkali."

I believe it is reasonable to assume that the fellowship created by the Laundry Owners' Association and endowed at the Mellon Institute should be a fairly authoritative source of information, and I am not qualified, nor do I care to debate, the accuracy or inaccuracy of its laboratory findings, but I do feel that I am competent in a measure to discuss laundry procedures. The inference made in this paragraph of the article, if followed literally, or in part, cannot be productive of anything but harm to institutional laundries. I have taken the trouble to consult by telephone with a dozen of the larger laundries in Cleveland, and through them have received information as to the practice in other laundries, and I find that with three exceptions there are no laundries in Cleveland using soda ash. One of the three which is using it is a laundry that confines itself primarily to washing overalls.

It must be borne in mind, in a discussion of this kind, that the problem of a laundry operating for profit, and the problem of a laundry operating in a hospital, are two separate and distinct ones. It is requisite that the hospital wash its clothes with as great a degree of efficiency as possible, keeping in mind at all times that linens do not deteriorate nearly so much through wear as they do through laundry procedures, and that therefore the laundry procedure that is the easiest upon the clothes is the procedure to use. It would seem strange that if the premises established by the laboratory tests of the Mellon Institute fellowship are sound, that constituent members of this organization almost universally are not accepting the results of these tests in their businesses.

As regards the use of soda ash, first of all, it is not a free rinser. It cannot be removed from the clothes without an excessive use of neutralizing acid or bleach. The most common bleach is that of chlorine base, and an excessive amount of chlorine bleach used in clothes is irritating to the skin.

In the second place, commercial soda ash has an undue percentage of sulphates and irons which certainly are not of any particular value to cloth when it comes in contact with it.

In the third place, any compound that has an excessively high causticity and which is not rinsed completely out of the cloth will burn the cloth very definitely when placed under heat, such as a mangling process or ironing process. This can be very easily demonstrated by anyone with a very simple test.

In the fourth place, soda ash without the excessive use or bleach will turn your cloth gray, which is a thing that is not desirable.

Approximately the same information as contained in the YEAR BOOK article is given in a report of the Laundry Committee, and I am assuming that the information is from the same source.

I am sure that you will appreciate the spirit in which these comments are made.

FRANK E. CHAPMAN,
Director, Mount Sinai Hospital, Cleveland, Ohio.

TEMPORARY RECEIVING ROOM FOR CHILDREN

To the Editor of THE MODERN HOSPITAL:

We note your article in the November issue of THE MODERN HOSPITAL on the "Small Hospital Architectural Contest."

Our experience in small or even moderate sized hospitals, often up to 100 beds, is fairly universal; there is no provision for a temporary receiving room for children to guard against introducing infection; in addition there is no retiring room from the wards into which noisy or dying patients may be temporarily moved and cared for.

We believe that no hospital ought to be constructed in the future without both of these features being insisted upon and the necessities of this type of accommodation should not be left to haphazard administration. Such quarters should be set aside absolutely for these purposes, properly located, and it should be precluded from the possibility of the superintendent or any one else using them as private rooms for private patients or for any other purpose.

We are offering these suggestions for your thought in estimating the value of the plans submitted to you in the above referred to contest.

J. M. BALDY, M.D.
Commissioner of Public Welfare,
State of Pennsylvania.

"There is a middle course between a tremendous and a ridiculous remedy. To aim at the best conceivable may lead to failure. Look for the ideal but put it into the actual."—Florence Nightingale.

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Book Reviews and Current Hospital Literature

THE OUTLINE OF SCIENCE

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What H. G. Wells did for history, Professor J. Arthur Thomson has done for science. "The Outline of History" introduced the "best-seller" public to history in its origins, to history in its continuity and to history in its social significance. With the same engaging informality, Professor Thomson has said to the average reader, "Let me make you acquainted with my dear friend, Science," and in the first few sentences the popular reader learns what a really absorbing fellow Science is.

The editor's rare comprehension of scientific and popular values enables him to accomplish his purpose,—"to give the reader a clear and concise view of the essentials of present-day science so that he may follow with intelligence the modern advance and share appreciatively in man's continued conquest of his kingdom." Shorn of of its technical vocabulary, a barrier to popular understanding, the facts and theories which for centuries have fired the souls of scientists, now may kindle the imaginations of the common citizen. The accuracy of the volume is attested by scientists; its simplicity by the multitude of its readers.

Some there are who may question the author's recognition of psychic phenomena by his inclusion of a chapter on "Psychic Science" by Sir Oliver Lodge. It is a subject of controversy whether study in this field has progressed far to warrant it a place among the sciences.

The work is in four volumes, the final one off the press last month. Signed chapters by Julian S. Huxley on biology, Sir E. Ray Lankester on bacteria, and Sir Oliver Lodge appear within the compilation. Illustrations are profuse and arresting.

Scientific study is revolutionary and so many kingdoms of thought have been overthrown in the past generation or two that the most intelligent citizen can scarcely hope for a clear grasp of current theories. For such "The Outline of Science" fills a well-defined need.—M. W.

FLORENCE NIGHTINGALE

A Play in Three Acts by Edith Gittings Reid.[2]

In 1920 the Committee for Nursing Education offered a prize of $500 for the best play built around Florence Nightingale. This offer represented an effort to celebrate the Nightingale Centennial and was intended to stimulate interest in, and study of, Florence Nightingale's life and work. Twenty-eight plays were submitted to the committee appointed to award the prize. This committee consisted of Mrs. Minnie Maddern Fiske, Miss Marylka Modjeska, granddaughter of the famous actress, Miss Alice Beer, and Miss Lillian Wald; names that assured careful, painstaking study. The prize was awarded to Prof. Harold Newcomb Hillebrand of the University of Illinois, but a second play entitled "Florence Nightingale" by Edith Gittings Reid met with great favor and was awarded honorable mention.

Of the twenty-eight plays submitted to the committee the only one to reach the public in book form is Miss Reid's. We are glad that Miss Reid has had the courage of her convictions, for the literature of Florence Nightingale is enriched by this sympathetic presentation of this great leader, showing as it does close and intimate study of her character, as well as keen appreciation of her superb contributions to human welfare.

This play is one nursing instructors will be glad to place in the hands of their students for it is a character study that they would like to have them make their own. It requires no great gift of prophecy to predict that groups of student nurses will find it suitable for presentation on many festive occasions. It is a gracious and subtle compliment to dedicate it to a nurse, and the summing up to the foreword is a clever portrayal of the many-sided genius of the heroine.—C. E. G.

THE NEWER KNOWLEDGE OF NUTRITION

By E. V. McCollum, Phd., Sc.D., Professor of Chemical Hygiene in the School of Hygiene and Public Health of the Johns Hopkins University, Baltimore, Md.[3]

The latest edition of "The Newer Knowledge of Nutrition" has been rewritten rather than revised. It is also enlarged, containing 449 pages whereas the first edition contained only 199 pages.

The first chapters are devoted to a review of experimental work on this subject. In following the development of the science of nutrition from the time when energy and protein were regarded as the most important factors in nutrition through the numerous contributions of chemists, physiological chemists, biologists and pathologists, he has given us an interesting history of the discoveries in these various phases of the subject and the application of these discoveries in obtaining practical information. The author states in the preface that, "during recent years, he has devoted much study to the dietary habits of peoples in different parts of the world with a view to correlating the results of animal experimentation with those of human experience in the use of different types of diets." The results of this study are summoned up in this volume.

The dietitian and other hospital workers will find the

1. G. P. Putnam's Sons, New York and London, 1922.
2. The Macmillan Company, New York, 1922.
3. The Macmillan Company, New York, 1922.

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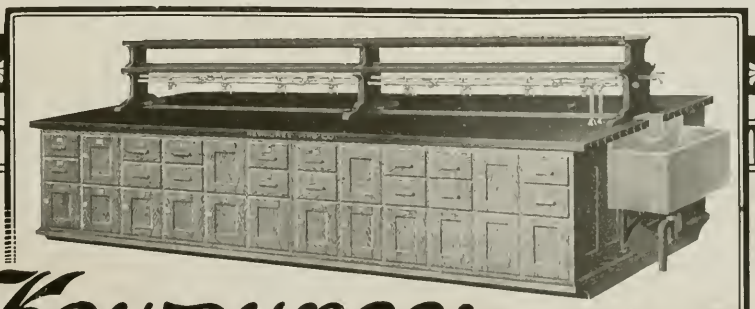

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chapters on "Dietary Properties of Food Stuffs" and "The Dietary Deficiency Diseases" to be of special value. In the final chapters evidence is given to support the author's claim that lowered resistance to infection, defective bone and tooth formation, and lack of physical vigor may be some form of a deficiency disease, and that proper nutrition is of greater value of preventive medicine than in cure of disease.—L. G. G.

THE VITAMINE MANUAL

By Walter H. Eddy, Associate Professor Physiological Chemistry Teachers' College, Columbia University.[4]

and

THE VITAMINES

By H. C. Sherman, Professor of Food Chemistry, Columbia University, and S. L. Smith, Specialist in Biological and Food Chemistry, United States Department of Agriculture.[5]

The nutrition worker may well feel that he (or she) is being "favored of the gods" when two such books as the above are published in one season. So much is being said and written today about vitamines that one is tempted to give heed to none of it, but the authors of both of these books are accepted authorities on the subject.

Professor Eddy states in the preface of "The Vitamine Manual" that his purpose in preparing this manual was to put into form for the student and lay-reader concise information and existing data on this subject and thus enable him to get information without having to read so extensively as is necessary in most of the literature which is available. He has given us a very readable account of the subject. The material is so divided that one can follow details necessary for laboratory work without going into the historical matter and vice versa, and while this material is valuable for the research worker it is written in language which the non-technical can readily understand.

On the contrary, "The Vitamines" is one of a series of scientific monographs being issued by the American Chemical Society, and the non-technical reader is advised to read the last chapter first. The American Chemical Society is publishing this series for the expressed purpose of presenting knowledge of the chosen topic to those chemists "whose activities may be along a wholly different line," and to "promote research in the branch of science covered by the monograph."

The first chapter gives a brief history of investigation on the subject of vitamines up until the end of 1921. The second, third and fourth chapters discuss in detail Vitamine B, Vitamine C and Vitamine A, respectively. The fifth and last chapter is devoted to vitamines in the problem of food supply. This is a summary of nutritive requirements and is decidedly worth while, but one wonders why it is tacked on the end of a highly scientific discussion.

Each of these books have an extensive bibliography and many references of value. For the nutrition workers, whether in hospitals or elsewhere, the material in these books will be a valuable aid, and if one can have both, he is fortunate indeed.—L. G. G.

4. Williams & Wilkins Company, Baltimore, 1921.
5. The Chemical Catalog Company, Inc., New York, 1922.

MANAGEMENT OF THE SICK INFANT

By Langley Porter, B.S., M.D., M.R.C.S., (Eng.), LR.C.P., (London), Professor of Clinical Pediatrics, University of California Medical School; Visiting Physician, San Francisco Children's Hospital; Consulting Pediatrician, Babies' Hospital, Oakland, Cal., Consulting Pediatrician, Mary's Help Hospital, San Francisco, and William E. Carter, M.D., Assistant Pediatrician and Chief of Out-Patient Department, University of California Medical School; Attending Physician, San Francisco Hospital, San Francisco.[6]

For the first time in the history of American pediatrics a book has been devoted entirely to the treatment and management of the sick infant. It is interesting to see a textbook that does not follow the general outline adopted by textbook writers such as etiology, pathology, symptoms, diagnosis and treatment.

Langley Porter and William E. Carter have succeeded in giving a general view of all diseases of infancy without putting it in a narrow frame. The line of treatment advocated by these two authors is modern and up-to-date. It is evident that the authors have based their views on experience gained in many years of practice. The book constitutes a contribution to pediatrics. It is a volume of value to the practising physician and at the same time is intelligible and of value to nurses and those responsible for the institutional care of sick children.—A. L.

6. C. V. Mosby Company, St. Louis, 1922.

BOOKS RECEIVED

HUGHES' PRACTICE OF MEDICINE, Including a Section on Mental Diseases and One on Diseases of the Skin. Twelfth Edition. By R. J. E. Scott, M.A., B.C.L., M.D., New York. Fellow of the New York Academy of Medicine; Fellow of the American Medical Association; Formerly Attending Physician to the Demilt Dispensary; Formerly Attending Physician to the Bellevue Dispensary; Author of "The State Board Examination Series"; Editor of "Witthaus' Textbook of Chemistry," "Witthaus' Essentials of Chemistry and Toxicology," "The Practitioner's Medical Dictionary," Gould and Pyle's "Cyclopedia of Medicine and Surgery"; etc. With 63 illustrations. Philadelphia, P. Blakiston's Son & Co.

EVERYCHILD'S BOOK. By Mrs. Frederick Peterson, Illustrated by Jessie Gillespie. The Macmillan Company, New York, 1922.

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